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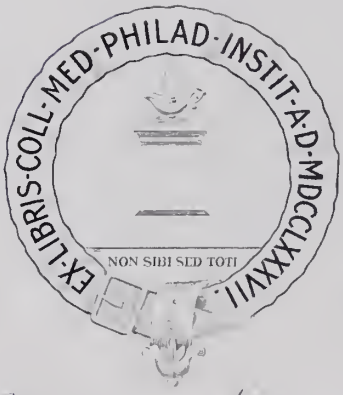

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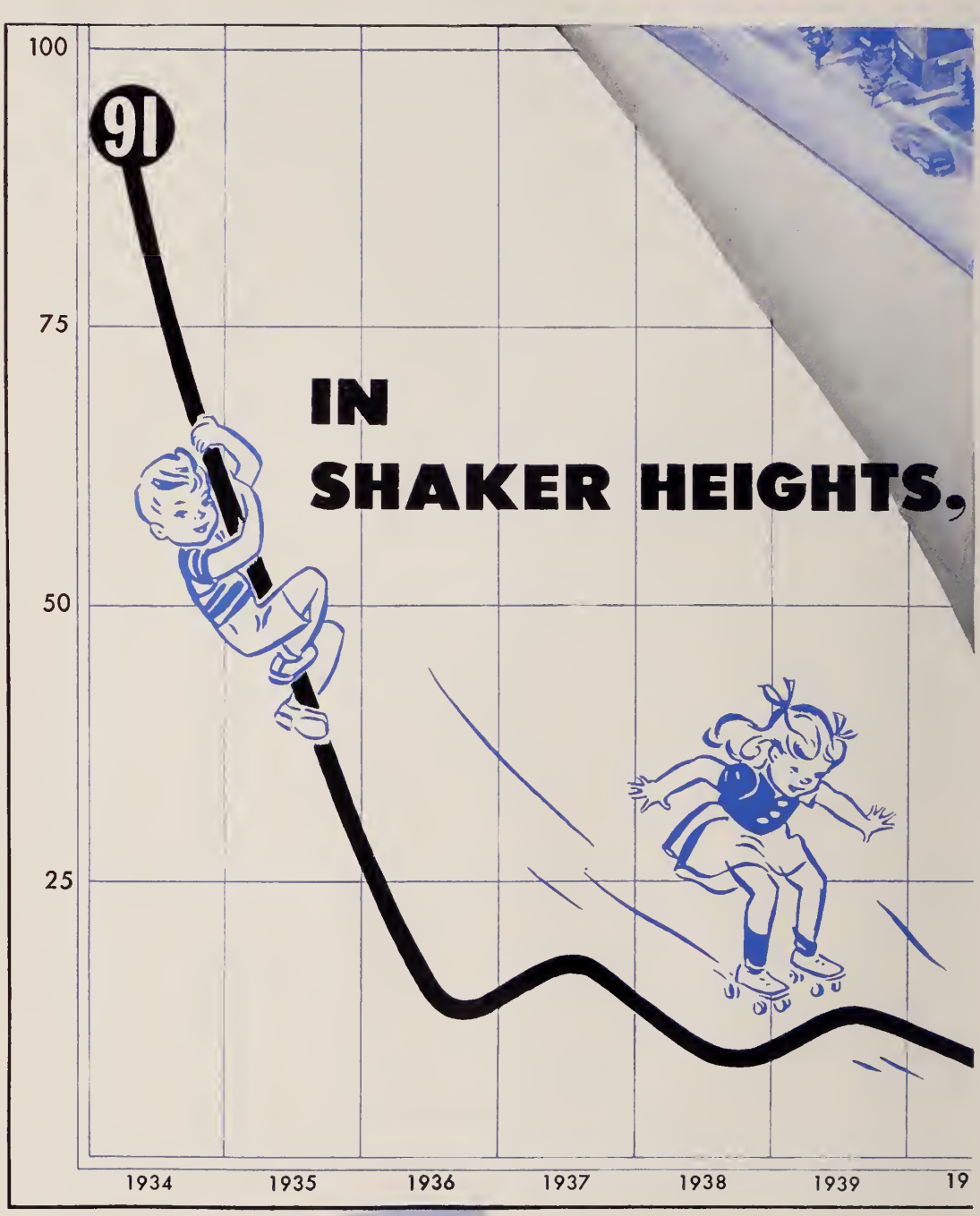

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[1] Garvin, J. A., Ohio State M. J. 41:229, 1945.

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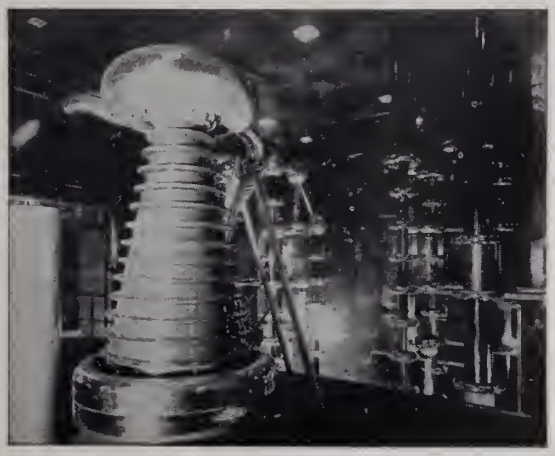

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*" . . . in a variety of medical and surgical conditions there may occur a considerable depletion of body protein owing to a combination of factors, of which the two most important are a generally diminished protein intake and an enhanced protein catabolism. This situation inhibits wound healing, renders the liver more liable to toxic damage, impedes the regeneration of hemoglobin, prevents the resumption of normal gastrointestinal activity and delays the full return of muscular strength. It is obvious that to meet the situation an adequate supply of proteins and calories must be made available to the body. . . . This implies at least 150 Gm. of protein and 3500 calories, with as much as 500 Gm. of protein daily when trauma has been severe, as in serious burns." (HOFF, H. E.: Physiology, New England J. of Med. 231:492 [Oct. 5] 1944.)

**"Cannon . . . cites the evidence which indicates that diminished protein intake lowers resistance to infectious disease, and corroborates it by his own experiments . . . it seems probable that the small intestine is better adapted for handling protein (especially meat protein) than for other types of food. . . . it is especially well supplied with enzymes which attack protein, and the digestion of meat has been shown to be more complete than that of foods of vegetable origins." (CRANDALL, L. A., Jr.: The Clinical Significance of the Plasma Proteins, Memphis M.J. XIX:147 [Oct.] 1944.)

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods and Nutrition

AMERICAN MEAT INSTITUTE

MAIN OFFICE, CHICAGO . . . MEMBERS THROUGHOUT THE UNITED STATES

No food (except breast milk) is more highly regarded than Similac for feeding the very young, small twins, prematures, or infants who have suffered a digestive upset. Similac is satisfactory in these special cases simply because it *resembles breast milk so closely,* and normal babies thrive on it for the same reason. This similarity to breast milk is definitely desirable — *from birth until weaning.*

A powdered modified milk product especially prepared for infant feeding, made from tuberculin tested cow's milk (casein modified) from which part of the butterfat is removed and to which has been added lactose, olive oil, cocoanut oil, corn oil, and fish liver oil concentrate.

One level tablespoon of Similac powder added to *two* ounces of water makes *two* fluid ounces of Similac. This is the normal mixture and the caloric value is approximately 20 calories per fluid ounce.

SIMILAC } **SIMILAR TO BREAST MILK**

M & R DIETETIC LABORATORIES, INC. • COLUMBUS 16, OHIO

Prescribe Journal-advertised products and you prescribe the best.

CAMEL CIGARETTES

Medical Relations Division

ONE PERSHING SQUARE
NEW YORK 17, N.Y.

Dear Doctor:

You may recall having been asked the question: "What cigarette do you yourself smoke, Doctor?"

In the past few months every physician in private practice in the United States has been asked that same question...asked solely and clearly on the basis of personal preference as a smoker.

Three nationally known independent research groups did the asking in what we believe is one of the most impartial and most comprehensive surveys of physician preference ever conducted.

You may or may not be a cigarette smoker, but we believe you will be interested not only in the results of these surveys, but in the methods by which these results were obtained.

Yours very truly,

A. G. Clarke.

A. G. Clarke
Director
Medical Relations Division

CALEDONIA 5-1910

A physician asked us the question first—

A smoker himself, he asked: "What cigarette do most doctors smoke?"

We know that many physicians smoke, that many of them prefer Camels; but we couldn't answer the doctor's query.

We turned the question over to three nationally known independent survey groups. For months these three groups worked . . . separately . . . each one employing the latest scientific fact-finding methods.

This was no mere "feeling the pulse" poll. No mere study of "trends." This was a nationwide survey to discover the actual fact . . . and from the statements of physicians themselves.

> *To the best of our knowledge and belief, every physician in private practice in the United States was asked: "What cigarette do you smoke?"*

The findings, based on the statements of thousands and thousands of physicians, were checked and re-checked.

ACCORDING TO THIS RECENT NATIONWIDE SURVEY:

More doctors smoke Camels than any other cigarette

And by a very convincing margin!

Naturally, as the makers of Camels, we are gratified to learn of this preference. We know that no one is more deserving of a few moments to himself than the busy physician . . . of a few moments of relaxation with a cigarette if he likes. And we are glad to know that so many more physicians find in Camels the same added smoking pleasure that has made Camels such an outstanding favorite among *all* smokers.

CAMELS *Costlier Tobaccos*

R. J. Reynolds Tob. Co.
Winston-Salem, N. C.

White's

COD LIVER OIL CONCENTRATE

WHOLLY NATURAL SOURCE

LOW COST PER DAY

WELL TOLERATED

These are advantages which, for many years, have fixed White's Cod Liver Oil Concentrate in the minds of physicians everywhere as their first thought in prescribing.

TO THESE ADVANTAGES ADD *economy*

Cost to the patient has *not* increased. Average "infant antirachitic" prophylactic dosage costs *still* less than a penny a day.

Three palatable, convenient dosage forms — LIQUID (for drop dosage to infants), TABLETS AND CAPSULES.

Ethically promoted — not advertised to the laity.

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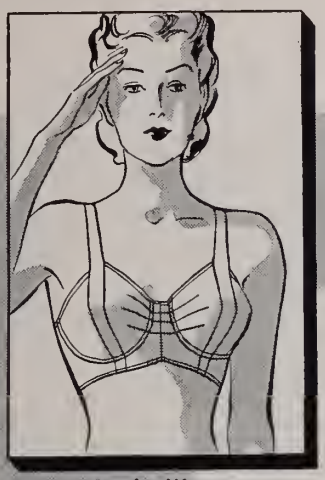
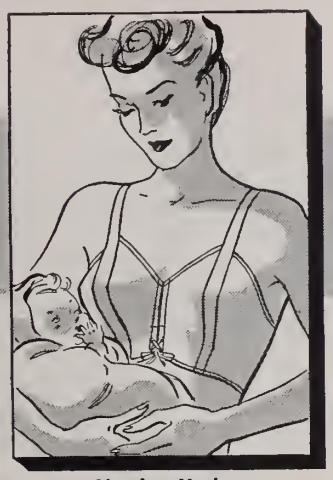
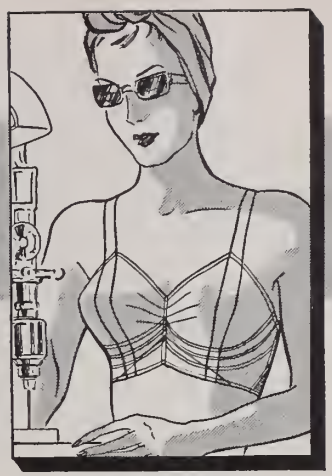


Service Woman



Nursing Mother



War Worker

CORRECTIVE HYGIENIC BREAST SUPPORT DESIGNED TO MEET THE SPECIFIC NEED OF THE INDIVIDUAL WOMAN

Lov-é Brassieres

IN MORE THAN 500 BUST-CUP-TORSO SIZE VARIATIONS

Proper physiological breast support for women in wartime is a subject that deserves the physician's thoughtful consideration.

That such consideration is being given this medical problem is attested by the fact that today, more Lov-é Corrective Brassieres are being fitted in accordance with physicians' prescriptions than at any time during the past twelve years.

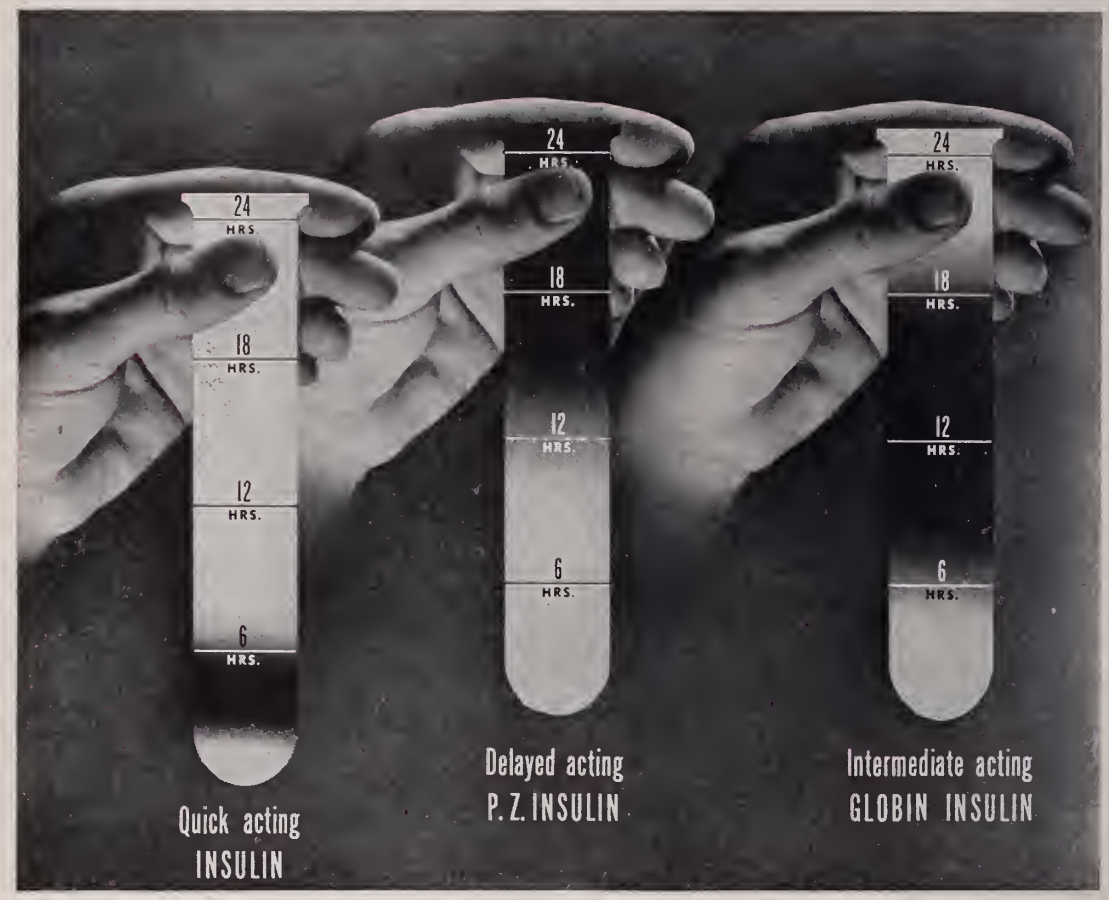
Lov-é's highly specialized line of therapeutic breast supports enables the physician to prescribe remedial support for the individual patient with the complete assurance that the correct model indicated will be fitted from the more than 500 bust-cup-torso size variations available. Special corrective models have been designed for specific breast conditions, such as, ptotic, atrophic, hypertrophic, prenatal, postnatal, amputation, and post-operative. Also available: sleeping brassieres, hospital binders, artificial breasts, anatomically designed muscle pads, and maternity garter supports.

LOV-É PRODUCTS ARE EXPERTLY FITTED IN EXACT ACCORDANCE WITH THE PHYSICIAN'S PRESCRIPTION BY FACTORY-TRAINED LOV-É BRASSIERE TECHNICIANS

WAR BONDS FOR VICTORY!

Dreyer-Meyer Corset Shop
704 North Milwaukee Street Phone Broadway 1234
Milwaukee, Wisconsin

Evolution of the 3rd insulin . . .



A NEW type of insulin is available for the diabetic —Globin Insulin. First there was a quick-acting but short-lived form. Next came a slow-acting but prolonged type. Now there is the intermediate-acting 'Wellcome' Globin Insulin with Zinc. Activity begins with moderate promptness yet it continues for sixteen or more hours, sufficient to cover the periods of maximum carbohydrate intake. Activity diminishes by night so that nocturnal reactions are minimal.

A single injection daily of 'Wellcome' Globin Insulin with Zinc controls the hyperglycemia of many patients. Physicians are rapidly learning to take advantage of this new third form of insulin when prescribing for their patients.

'Wellcome' Globin Insulin with Zinc is a clear solution, comparable to regular insulin in its freedom from allergenic properties.

Accepted by the Council on Pharmacy and Chemistry, American Medical Association. Developed in the Wellcome Research Laboratories, Tuckahoe, New York. U.S. Patent No. 2,161,198. Available in vials of 10 cc., 80 units in 1 cc. and vials of 10 cc., 40 units in 1 cc. Literature on request. 'Wellcome' trademark registered.

'WELLCOME' Globin Insulin WITH ZINC

BURROUGHS WELLCOME & CO. (U.S.A.) INC., 9 & 11 EAST 41ST STREET, NEW YORK 17, N. Y.

You'd think he was 70

With his "fussy" appetite, intestinal upsets and restless sleep, you'd think he was 70 years instead of 7 weeks old. A change to 'Dexin' brand High Dextrin Carbohydrate formulas often helps restore a normal, healthy appetite, and sound, undisturbed sleep. The high dextrin content of 'Dexin' (1) diminishes intestinal fermentation and the tendency to colic and diarrhea, and (2) promotes the formation of soft, flocculent, easily digested curds.

'Dexin' provides formulas that are well taken and retained. Palatable and not too sweet, 'Dexin' is soluble in hot or cold milk or other bland foods. 'Dexin' does make a difference.

'Dexin' Reg. Trademark

'Dexin'

HIGH DEXTRIN CARBOHYDRATE

Composition—Dextrins 75% • Maltose 24% • Mineral Ash 0.25% • Moisture 0.75% • Available carbohydrate 99% • 115 calories per ounce • 6 level packed tablespoonfuls equal 1 ounce • Containers of twelve ounces and three pounds • Accepted by the Council on Foods and Nutrition, American Medical Association.

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BURROUGHS WELLCOME & CO. (U.S.A.) INC., 9 & 11 East 41st St., New York 17, N. Y.

Doctor—Judge

PHILIP MORRIS suggests *you* judge . . . from the evidence of your own *personal* observations . . . the value of PHILIP MORRIS Cigarettes to your patients with sensitive throats.

PUBLISHED STUDIES* SHOWED WHEN SMOKERS CHANGED TO PHILIP MORRIS SUBSTANTIALLY EVERY CASE OF THROAT IRRITATION DUE TO SMOKING CLEARED COMPLETELY, OR DEFINITELY IMPROVED.

But naturally, no published tests, no matter how authoritative, can be as completely convincing as results you will observe for yourself.

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PHILIP MORRIS & CO., LTD., INC.
119 FIFTH AVENUE, NEW YORK, N. Y.

**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154.*
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60.

TO THE DOCTOR WHO SMOKES A PIPE: We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

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Chicago Medical Society

WHAT—

Annual Clinical Conference

WHEN—

March 5, 6, 7, 8, 1946

WHERE—

Palmer House, Chicago, Illinois

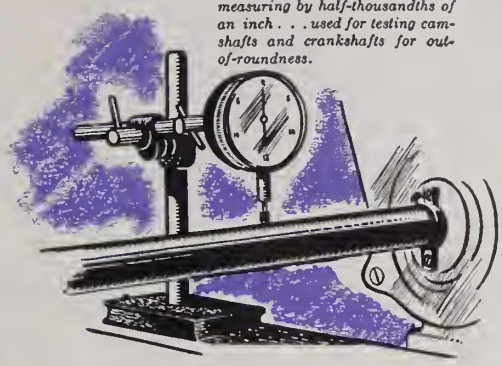
WHY—

- For daily scientific programs consisting of half-hour lectures and clinics, beginning at 8:30 A. M. and continuing until 5:00 P. M.
- To inspect scientific and technical exhibits
- To hear new ideas presented by outstanding clinicians from all sections of the United States
- To renew acquaintances
- To relax away from your own office
- To attend a banquet on Thursday night

HOW—

By making YOUR reservation through The Chicago Convention Bureau, 33 North LaSalle Street, Chicago 2, Ill.

Registration Fee $5.00



DIAL TEST INDICATOR measuring by half-thousandths of an inch . . . used for testing camshafts and crankshafts for out-of-roundness.

WHEN IT'S *Precision*

YOU REQUIRE . . .

FOR the treatment of pernicious anemia, medical science has found a specific in liver therapy.

But like the highly sensitive dial test indicator which measures within .0005 inch, liver extract—to give precise results—must be manufactured with the utmost care.

. . . *And nothing less than precision will meet the requirements of the competent physician.*

For these requirements, Purified Solution of Liver, Smith-Dorsey, deserves your confidence.

Its uniform purity and potency are traceable to the conditions under which it is produced—to the capably staffed laboratories, the modern facilities, the rigidly standardized testing procedure.

You may be assured of *precision* in liver therapy when you use

PURIFIED SOLUTION OF *Liver*

SMITH-DORSEY

Supplied in the following dosage forms: 1 cc. ampoules and 10 cc. and 30 cc ampoule vials, each containing 10 U.S.P. Injectable Units per cc.

THE SMITH-DORSEY COMPANY
Lincoln, Nebraska

Manufacturers of Pharmaceuticals to the Medical Profession Since 1908

at home, in your own country

To those of you who left your homes to serve your country we extend a warm and friendly welcome, a happy welcome home. The extraordinary service the medical profession gave in the war can't be told here. Here we want to say how glad we are to have you back again, away from the heavy change of war; back into your proper sphere, back again into your peace-time practice, back to a long, peaceful, happy service in the nation's health. ▸ ▸ ▸ Back again at home, in your own country.

GENERAL ELECTRIC X-RAY CORPORATION

Ad No. 2500A—6 x 9 in.—Medical & Hospital Publications—Jan. 1946—Job No 32051

Not for just a year

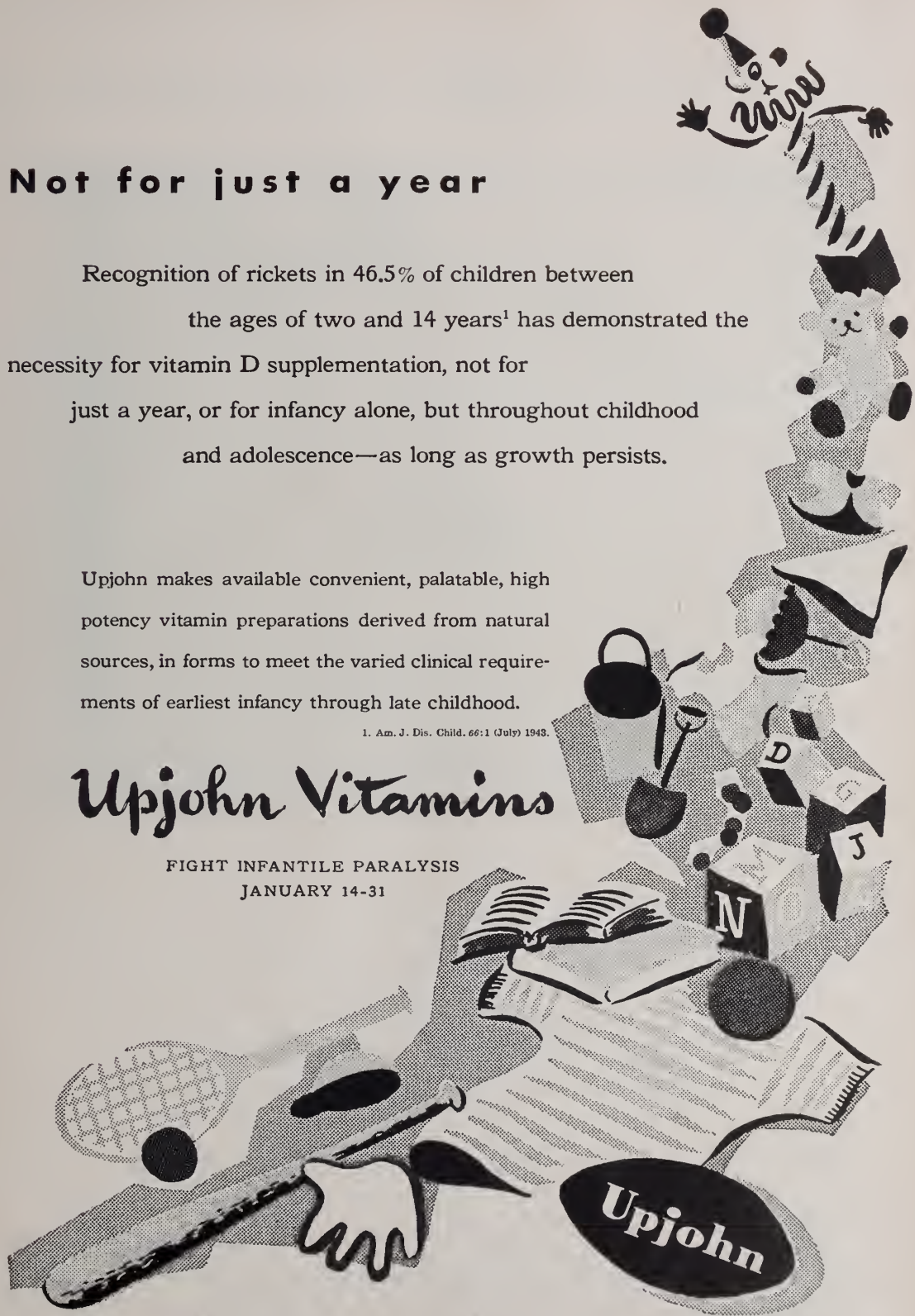
Recognition of rickets in 46.5% of children between the ages of two and 14 years[1] has demonstrated the necessity for vitamin D supplementation, not for just a year, or for infancy alone, but throughout childhood and adolescence—as long as growth persists.

Upjohn makes available convenient, palatable, high potency vitamin preparations derived from natural sources, in forms to meet the varied clinical requirements of earliest infancy through late childhood.

1. Am. J. Dis. Child. *66*:1 (July) 1943.

Upjohn Vitamins

FIGHT INFANTILE PARALYSIS
JANUARY 14-31



FINE PHARMACEUTICALS SINCE 1886

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The Cosmetic Effect OF OPTICAL DESIGN

Because a man makes neatness his sole requirement in glasses, designers may consider him no problem. What they overlook is that a man's definition of neatness bears no time limit. Weeks after he has bought glasses, the loosening of a mounting is sufficient to make him discontented. To obviate this, Uhlemann has developed one of the most ingenious improvements in optical design. It mounts rimless lenses by slotting and cementing—rather than drilling them. Thus it removes the source of weakening strain. Keeps lenses from loosening and wobbling out of alignment for months, even years, after they have been mounted. The name of this improvement is Uhlemann's EVERLOCT (illustrated here by the Numont Upton). Remember it and recommend it to your patients. They'll thank you for the tip.

UHLEMANN OPTICAL COMPANY

ESTABLISHED 1907

Exclusive Opticians for Eye-Physicians

55 East Washington Street • Pittsfield Building • Chicago, Illinois

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CHICAGO • OAK PARK • EVANSTON • ROCKFORD • TOLEDO • SPRINGFIELD • APPLETON • DAYTON • DETROIT

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For the treatment of Alcoholism only

Located on Milwaukee's restful East Side, near Lake Michigan, Samaritan is beautifully appointed and home-like

Samaritan's conditioned reflex treatment for problem drinking is not merely a sobering up method. It is an established technique to overcome the alcoholic syndrome.

Factual results are gratifying to physician and patient alike.

Brief hospitalization. Ambulatory after care.

Competent medical and psychiatric supervision.

Alcoholics only-treated in pleasant privacy.

Phone anytime — LAKESIDE 4011 or Marquette 1290.

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MILWAUKEE 2, WISCONSIN

Prescribe Journal-advertised products and you prescribe the best.

IN THE SHORTENING OF *Convalescence*

More than so-termed tonics and restoratives, Ovaltine can be of material aid in shortening the period required for the return of strength and vigor following recovery from infectious or prolonged illnesses. During the acute stages of febrile diseases, when the patient's nutritional intake is low, while requirements are higher than normal, many metabolic deficits are developed. These can be made good only by a high intake of essential nutrients during the recovery period, for only after these nutritional deficits are wiped out can former strength and well-being return.

Ovaltine offers many advantages as a nutritional supplement to the diet of convalescence. This delicious food drink is rich in needed minerals, vitamins, and biologically adequate proteins. Its appealing taste invites consumption of three or more glassfuls daily. Its notably low curd tension encourages rapid gastric emptying, an important factor in maintaining good appetite.

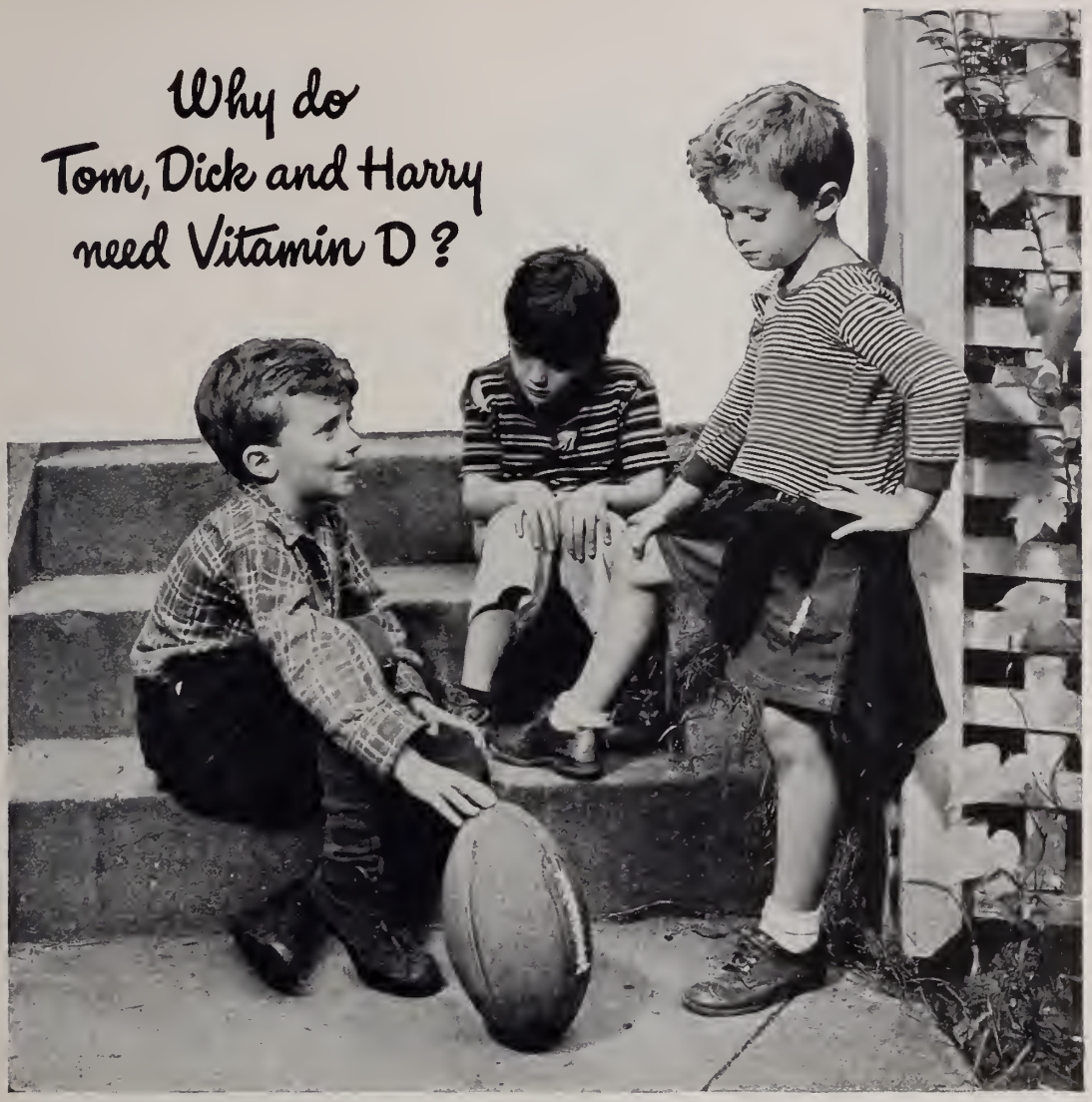
THE WANDER COMPANY, 350 N. MICHIGAN AVE., CHICAGO 1, ILL.

Ovaltine

Three daily servings of Ovaltine, each made of ½ oz. Ovaltine and 8 oz. of whole milk,* provide:

PROTEIN	31.2 Gm.	VITAMIN A	2953 I.U.
CARBOHYDRATE	62.43 Gm.	VITAMIN D	480 I.U.
FAT	29.34 Gm.	THIAMINE	1 296 mg.
CALCIUM	1.104 Gm.	RIBOFLAVIN	1.278 mg.
PHOSPHORUS	.903 Gm.	NIACIN	7.0 mg.
IRON	11.94 mg.	COPPER	.5 mg.

*Based on average reported values for milk.



Growing children require vitamin D mainly to prevent rickets. They also need vitamin D, though to a lesser degree, to insure optimal development of muscles and other soft tissues containing considerable amounts of phosphorus . . . Milk is the logical menstruum for administering vitamin D to growing children, as well as to infants, pregnant women and lactating mothers. This suggests the use of Drisdol in Propylene Glycol, which diffuses uniformly in milk, fruit juices and other fluids.

DRISDOL IN PROPYLENE GLYCOL

TRADEMARK REG U S. PAT. OFF & CANADA

Brand of Crystalline Vitamin D_2 (calciferol) from ergosterol

MILK DIFFUSIBLE VITAMIN D PREPARATION

Odorless Tasteless Economical

Average daily dose for infants 2 drops, for children and adults 4 to 6 drops, in milk.

Available in bottles of 5, 10 and 50 cc. with special dropper delivering 250 U.S.P. units per drop.

WINTHROP CHEMICAL COMPANY, INC.

Pharmaceuticals of merit for the physician • New York 13, N.Y. • Windsor, Ont.

a clinical supply

free!

If you would like a supply of sample-size Benzedrine Inhalers—*free of charge and without obligation*—just write "Six Inhalers" on your prescription blank and mail to *Smith, Kline & French Laboratories, Dept. 34, 429 Arch St., Phila. 5, Pa.*

sample size

"MEASURED POTENCY" . . .

one of the reasons why doctors consider PAGE Special EVAPORATED MILK

It is a scientifically recognized fact that you can accurately measure the vitamin potency of fish liver oils and their concentrates. Based upon this factor of "known strength", Page Special Evaporated Milk is fortified by adding sufficient quantities of biologically assayed fish liver oil concentrate to assure a minimum of 2000 USP units of vitamin A and 400 USP units of vitamin D per reconstituted quart.* These are vitamins from natural sources, known to agree with a normal baby's delicate digestive system.

Yes, the known strength of vitamin potency plus the full-flavor richness of wholesome milk, processed under strictly sanitary conditions, make Page Special the evaporated milk for you to recommend. At chain or independent food stores in the orange and black label featuring the twins.

* The vitamin A and vitamin D units added to Page Special are in addition to those vitamins A and D naturally present in wholesome evaporated milk. Thus when you prescribe Page Special you are providing a margin of safety—giving absolute assurance that minimum requirements for these vitamins are met.

Fortified with
VITAMINS
A AND D

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods and Nutrition

The PAGE MILK CO.
MERRILL • WISCONSIN

In the City of Baqdad lived Hakeem, the Wise One, and many people went to him for counsel, which he gave freely to all, asking nothing in return.

There came to him a young man, who had spent much but got little, and said: "Tell me, Wise One, what shall I do to receive the most for that which I spend?"

Hakeem answered: "A thing that is bought or sold has no value unless it contains that which cannot be bought or sold. Look for the Priceless Ingredient."

"But what is this Priceless Ingredient?" asked the young man.

Spoke then the Wise One: "My son, the Priceless Ingredient of every product in the market-place is the Honor and Integrity of him who makes it. Consider his name before you buy."

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MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858

ARMOR AND ARMAMENTARIUM

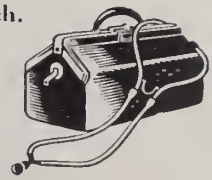
Guns are silent and grass grows in the foxholes, but there can be no peace treaty in the endless war on mankind's immortal enemy—Disease. Home comes the physician from his lifesaving on the battlefields of man-made death abroad to march again beside his colleagues who have so valiantly held the casemates of health at home.

Battle front and home front, boulevard and dirt road, the mighty facilities of the medical center and the challenge of practice in the lonely farmhouse—all are the front line trenches in humanity's continuing crusade to tame cannibal protoplasm. There is no discharge in that war.

The first cry of pain in the world was the first call for a physician. It has been answered as it echoed down the centuries; it will be answered in the unrolling years of the future.

As this questioning year of 1946 opens with the world convalescing from malignant political disease, we would like to claim the privilege of welcoming the thousands of physicians returning from unparalleled service on war fronts—of saluting those who shouldered such heavy burdens at home—of expressing the confidence that the traditional unity of the profession armed with new and potent weapons will drive the front lines of the war on disease ever forward.

We know that we are joined in this expression by all organizations which seek to play their roles, large and humble, as institutions of supply to those "bound by the covenant and oath, according to the law of medicine." S. H. Camp and Company, Jackson, Mich.



HOW AO *Weymouth Ful-Vue*

Provides Better Fitting In Zyl

In the AO Weymouth modern styling is carefully combined with recognized ophthalmic standards. This new zyl frame conforms to the natural orbit; provides full lens coverage. Weymouth's advanced bridge styling brings lenses nearer the nose—permitting larger lenses with less distance between lenses for the same interpupillary distance.

American AO Optical
COMPANY

PAT. PENDING

Our Professional Fitting Service of Camp Supports To Promptly and Accurately Fill Your Prescriptions

For more than fifteen years the Dreyer-Meyer Corset Shop has been rendering to physicians, as well as to women of this city and state, a very important and specialized service in the fitting of Camp Anatomical supports. Our always large and complete stocks of all types of Camp supports, as well as professionally trained fitters, assure physicians that all prescriptions will be promptly and accurately filled. Equipped with surgical room and fitting table.

CAMP Supports | Authorized CAMP Service

DREYER-MEYER CORSET SHOP
704 No. Milwaukee St. Milwaukee, Wis.
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Introducing

Vasano

FOR TRAVEL SICKNESS

Investigators in the medical corps of the United States Navy, the British Royal Navy, the air forces and elsewhere have demonstrated that hyoscine (scopolamine), whose effects are afforded by VASANO, is the best single agent for the treatment of all forms of travel sickness.[1-4]

VASANO, Schering's hyoscine and hyoscyamine preparation, brings to civilian practice the proved benefits of this war-time therapeutic advance.

Consistently most effective for seasickness as well as a "potent preventive of airsickness" hyoscine causes no harmful side effects in recommended dosage.

Adult Dose: Two tablets or one suppository 1 to 2 hours before departure, repeated in 3 to 4 hours if necessary. A total of four tablets in 24 hours should not be exceeded.

VASANO Tablets are supplied 12 to a box; Suppositories 10 to a box.

1. Holling, H. E.; McArdle, B., and Trotter, W. R.: Lancet, *1*:127, 1944.
2. Hill, I. G. W., and Guest, A. I.: Brit. M. J. *2*:6, 1945.
3. A Critical Study of Seasickness Remedies, No. 4, Royal Naval Medical Bulletin *24*:3, 1943, Abstracted, Bulletin of War Medicine *18*:1242, 1944.
4. Lillienthal, J. L.: Jl. Aviation Med. *16*:59, 1945.

Trade Mark VASANO—Reg. U. S. Pat. Off.

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IN CANADA, SCHERING CORPORATION LIMITED, MONTREAL.

RADON SEEDS

FOR safety and reliability use composite Radon seeds in your cases requiring interstitial radiation. The Composite Radon Seed is the only type of metal Radon Seed having smooth, round, non-cutting ends. In this type of seed, illustrated here highly magnified, Radon is under gas-tight, leak-proof seal. Composite Platinum (or Gold) Radon Seeds and loading-slot instruments for their implantation are available to you exclusively through us. Inquire and order by mail, or preferably by telegraph, reversing charges.

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MILWAUKEE OPTICAL COMPANY

208 E. WISCONSIN AVE.

MILWAUKEE, WISCONSIN

SHOULD VITAMIN D BE GIVEN ONLY TO INFANTS?

VITAMIN D has been so successful in preventing rickets during infancy that there has been little emphasis on continuing its use after the second year.

But now a careful histologic study has been made which reveals a startlingly high incidence of rickets in children 2 to 14 years old. Follis, Jackson, Eliot, and Park* report that postmortem examination of 230 children of this age group showed the total prevalence of rickets to be 46.5%.

Rachitic changes were present as late as the fourteenth year, and the incidence was higher among children dying from acute disease than in those dying of chronic disease.

The authors conclude, "We doubt if slight degrees of rickets, such as we found in many of our children, interfere with health and development, but our studies as a whole afford reason to prolong administration of vitamin D to the age limit of our study, the fourteenth year, and especially indicate the necessity to suspect and to take the necessary measures to guard against rickets in sick children."

*R. H. Follis, D. Jackson, M. M. Eliot, and E. A. Park: Prevalence of rickets in children between two and fourteen years of age, Am. J. Dis. Child. 66:1-11, July 1943.

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. . . . THE PRESIDENT'S PAGE . . . .

Maintaining the Integrity of Our Institutions

SOMETIME in November President Truman sent a special message to Congress in which federalized medicine was endorsed. On December 2 the president of the State Medical Society of California, addressing the presidents of the state medical societies of the United States assembled in Chicago, stated that the plan for state medicine urged by Governor Warren of California was defeated by a margin that was not impressive but was supported by a vote that was truly formidable. Labor unions, women's clubs, and various service clubs supported Governor Warren's measure. Many physicians, he stated, were indifferent and many supported their state society's opposition grudgingly.

The scope of this page does not permit a discussion of state medicine. The sinister implications of the scheme have been indicated in many able articles that have appeared in the medical press. The tenor of medical thought indicates that a united profession, speaking through its representatives, can forestall this threat to the profession and to the sick people who are our special care. We may go farther and help in the saving of the whole fabric of true representative government. Certainly the common danger calls for society support and militant solicitude by every physician. With medicine on the defensive and its organized existence threatened there will be forces that will attempt our destruction that they may profit from our ruin. They will not deal directly and openly with our societies but will endeavor to disrupt us by covertly inciting dissension within our ranks. They will seek to monopolize medical practice independently or within the processes of law. They will make of us an adjunct to their program, and dissolve us as an entity. No physician can hold remuneration for his services as his first objective and live up to the stature of his moral responsibilities. It is not dishonorable for one who deals in ordinary goods and supplies to hold price and profit equally important with quality. That is the rule of the trader. We can not afford, however, to accept the surreptitious advances of traders, regardless of personal inducements, to the detriment of honest, ethical medicine. There is no place within our ranks for the covert collaborationist. Our welfare can be secure only if we maintain the integrity of our institutions by supporting them with unflagging loyalty.

P. R. Minahan

THE WISCONSIN MEDICAL JOURNAL

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« « « EDITORIALS » » »

Our Guest Editorialist

FIVE years ago an issue of *The Wisconsin Medical Journal* was dedicated to William Creighton Woodward, M. D., LL. M. who had recently retired after eighteen years as Director of the Bureau of Legal Medicine and Legislation of the American Medical Association.

It is particularly appropriate that the guest editorial in this ninth annual Blue Book edition of the *Journal* should be one contributed by Doctor Woodward, whose interest in the affairs of medicine, and its problems, is as keen now as it ever has been. In 1940 the *Journal* observed that "Dr. Woodward is learned not alone in the science of medicine, in the realm of law, and in the translation of the advances of science into the protection of the people by law. His is the richer and deeper learning of how to work with men. And because all of this lies in a man of direction, simplicity and public purpose, his contributions to the cause of public health are not to be measured in this generation."

Welcome, Doctor Woodward, to our editorial columns.

Legal Pitfalls For Medical Men

IGNORANCE of the law excuses no one and the presumption that everyone knows the law lies at the very foundation of law enforcement today. Every physician should take notice and equip himself accordingly. It is true that many a practitioner has during a lifetime of practice run the gantlet of medicolegal dangers without ever being enmeshed in the toils of the law, but that fact hardly justifies others in taking a chance today; Fate may not always be so kind.

A physician has certain legal duties to his patients and others to the government. Neglect or maladministration of either may bring to him serious results. Ignorance may result in an unintended crime, for which the penalty may be a fine, imprisonment, or forfeiture of the offender's license, or it may result in an injury to a patient that falls short of a crime, for which the physician must pay damages. The very same act or neglect may expose the physician to such a penalty and at the same time make him liable for the payment of damages. The bare institution of a criminal prosecution or a suit for damages will impose on the defendant physician the stigma that is popularly associate with such proceedings, and the disabling anxiety, the loss of time and energy, and expense incident to his defense, even though in the end the court gives judgment in his favor.

But viewing the maze of federal, state, and local constitutions, statutes, ordinances, rules, regulations, and orders, the practitioner may well ask how it is possible for him to learn what the law is that is to guide him through the many and diverse situations that lie ahead: licensure; registration to enable him professionally to employ narcotic and other habit-forming drugs; examinations and operations, say on minors, comatose or delirious persons, and married women; autopsies; compensation for services; malpractice; professional confidences; rights and duties as a witness; record-keeping and the making of reports; taxes; and so on. A knowledge of the law governing many of these topics need not be at all times in the practitioner's head: when questions arise, time will permit consultation with the proper authorities or with private counsel. Under other circumstances, however, the practitioner must make decisions instantly, at his own risk, possibly at the bedside or in the operating room; circumstances that give rise, for instance, to the question of restraining an insane or delirious person or even of operating on one who is semi-comatose or delirious, against his wishes and possibly against the wishes of his family or friends. In such situations a basic knowledge of the legal principles governing the physician-patient relationship is imperative and should be instantly at hand, generally out of the physician's own knowledge and experience.

Unfortunately federal laws and regulations generally differ from those of the several states; the laws and regulations of one state differ from those of others; and the ordinances, rules, regulations, and orders of one county, district, city, or town may differ from those of others. No physician, therefore, can find time to search out in the official law books of the federal government and those of the state in which he resides and of the several political subdivisions the laws relating to his daily practice, nor would he find time to interpret them all even if he were competent to do so. Fortunately for the physicians of Wisconsin, much of the labor of such a search and interpretation of the law as it relates to the practice of medicine within that state has been performed for them by the State Medical Society and is every year brought up to date and published for their use as the Medical Blue Book. The physician practicing in Wisconsin who is familiar with its contents may feel himself on safe ground and find a sound basis on which to enlarge his knowledge of the law governing practice if circumstances require. He has little excuse for going astray legally in his professional work.

The State Medical Society of Wisconsin is to be congratulated on the success of its efforts to familiarize the physicians of the state with the law governing their professional activities. It is entitled to the gratitude of the law enforcement officers of the state whose duties, in so far as they involve the laws relating to the practice of medicine, the Medical Blue Book must certainly have simplified.

Jm. C. Goodwin

Wisconsin's Medical Schools

University of Wisconsin Medical School

MADISON

WILLIAM S. MIDDLETON

Doctor Middleton was appointed Dean of the University Medical School in 1935. A 1911 graduate of the University of Pennsylvania School of Medicine, he has been connected with the Medical Department of the University of Wisconsin since 1912.

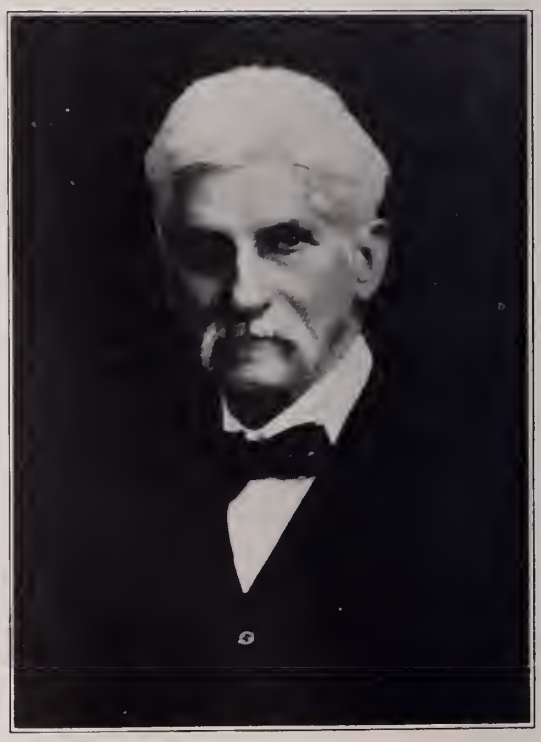
Doctor Middleton served with the Army Medical Corps from April, 1942, until September, 1945 as Chief Consultant in Medicine to the Surgeon General of the European theater.

HISTORICALLY the University of Wisconsin Medical School had its origin in the original legislative plan of the organization of the University in 1848 which included a "Department of Medicine." Subsequently the "Department of Medicine" was repeatedly authorized by the Legislature in 1866 and 1875. Meanwhile in 1854 the Regents of the University had decreed the establishment of a "Department of Medicine" in Madison, apparently upon advices of the State Medical Society of Wisconsin. Seven chairs were announced and a gradual enlistment of their occupants proceeded under Dr. Alfred L. Castleman of Delafield, Chairman of the Committee of the State Society, who was named professor of medicine and dean of the proposed school. Interestingly the proposed course required two years of "private pupillage" and two courses of lectures. An added course of lectures might be pursued in lieu of the "pupillage." The year 1858 was set for the opening of the Department of Medicine, but a lack of housing facilities led to its deferment.

In 1887 President Chamberlain announced the organization of the premedical course under the title of "Special Science Course Antecedent to Medicine." Dr. Edward A. Birge, whose long term of effective service to the University of Wisconsin remains a cherished tradition, was the most potent force in arranging this training. In 1892 the title was changed to "The Premedical Course." To the already existent courses in biology, chemistry, and physics were added histology, neurology, embryology, physiology, and bacteriology between 1890 and 1900. Another strong figure in the person of Dr. William Snow Miller made possible the introduction of the first three of these new subjects.

In 1904 Dr. Charles R. Bardeen came to Wisconsin as the professor of anatomy, and in 1907 the Legislature again authorized the Regents to establish a medical school. The first bulletin of the Medical School, 1906–07, outlined the courses preparatory to the study of clinical medicine, since the legislative action authorized only the first two years of medicine. Students completing such courses were required to transfer to other medical schools for their clinical training. The first organized class in the Medical School thereafter takes its origin in the session of 1907–08 when gross and microscopic anatomy, physiology, and biochemistry were offered. With the growth of the faculty and the addition of pathology, pharmacology, bacteriology, and hygiene (previously given in the College of Letters and Science), the second year of medicine followed in 1908–09. In 1910 the Department of Clinical Medicine was established under the leadership of Dr. Joseph Spragg Evans with the primary responsibility for Student Health Service but with a lesser function in teaching physical diagnosis and clinical laboratory diagnosis.

The physical evolution of the University of Wisconsin Medical School is extremely interesting. With the initiation of the two year course in 1907,



DR. EDWARD A. BIRGE (Circa 1910)

attic space was offered in Science Hall, the Chemical Engineering Building, and South Hall. In 1913, upon the movement of the Department of Zoology and Botany to the Biology Building, space was provided for bacteriology and pathology in Science Hall. Movement of the Department of Physics to Sterling Hall in 1917 afforded space for the transfer of the Departments of Physiology and Pharmacology from the attic of the Chemical Engineering Building to Science Hall. The Service Memorial Institutes for the Advancement of Medical Knowledge and its Application was authorized in 1925 but was not ready for occupancy until 1928. This fine edifice accommodates all of the preclinical departments except anatomy, which still remains in Science Hall. In addition the State Laboratory of Hygiene is quartered here.

The establishment of the complete medical course at the University awaited the tedious evolution of the clinical development. Obviously adequate hospital facilities were lacking for clinical teaching. With the creation of the Department of Clinical Medicine under the leadership of Dr. Joseph S. Evans, the small Cornelius house on State Street was used for office consultations. In 1912 the Olin house on Langdon Street was purchased by the Regents and an extension thereto constructed for office space. Upon the authority of the Regents in December, 1913, two wards at the Madison General Hospital were leased for the more adequate care of the student sick. In 1915 the Raymer property, adjacent to the Olin house of Langdon Street, was purchased as an infirmary. Through the munificence of friends of the Medical School, Mr. T. E. Brittingham and Mr. Carl Johnson, a legislative grant was duplicated and a modern Student Infirmary was erected in 1918. In 1931 its facilities were extended by a new wing. In 1918 the Mary Cornelia Bradley Memorial Hospital was donated by Mr. and Mrs. C. R. Crane and Dr. and Mrs. H. C. Bradley for the care of children and for clinical research. Its facilities have been utilized for many purposes in the intervening years. At first children either crippled or handicapped by congenital defects, such as hare lip or cleft palate, were treated here. Then clinical problems received attention. For example, the first clinical trial of insulin in this area was carried out at the Bradley Memorial Hospital. Since the construction of the State of Wisconsin General Hospital, it has served as a Neuropsychiatric Unit and has housed the Wisconsin Psychiatric Institute.

DR. CHARLES B. BARDEEN (Circa 1910)

DR. WILLIAM SNOW MILLER (1934)

In 1919 the Legislature authorized the Regents of the University to initiate the four year course in medicine. In 1920 to implement this plan a special session of the Legislature made liberal appropriations for the construction of the State of Wisconsin General Hospital and Nurses Dormitories as a memorial to those who served in World War I. Certain delays attended this program of construction, so that the opening of the hospital and dormitories was deferred until 1924. In the fall of 1925 the first class was accepted into the clinical years and in 1927

Early Medical School buildings including Science Hall, and the Clinic and Infirmary, between the landmarks of a former generation: the homes of President Van Hise and Dean Birge.

DR. JOSEPH S. EVANS (Circa 1910)

this group graduated. In the intervening years, 973 have received the degree of Doctor of Medicine from the University of Wisconsin Medical School.

Perhaps the most significant departure from conventional medical education at Wisconsin is the Preceptorial Plan. The late Dr. Charles B. Bardeen, who served as Dean from 1907 to his death in 1935, felt that the clinical training of medical students was entirely too centered in larger hospitals. This circumstance tended to limit the outlook and to dwarf the initiative of the medical student. With the growing complexity of modern life the impact of environment upon disease is admittedly great. Detached from these influences both patient and physician may lose sight of their importance. Doctor Bardeen visualized the tremendous benefit of a student-preceptor relationship in the opportunity of the student to work side by side with a sound practitioner in the untangling of such involved skeins. Not only has the practice proved a very valuable one but there is also the fine stimulus to the participating physicians of the state who are thrown into daily contact with alert young medical minds.

Largely through the efforts of the Wisconsin Association for the Disabled a splendid Orthopedic Hospital for Children was built adjacent to the State of Wisconsin General Hospital in 1929. Its facilities have met a continuing demand from the state at

An aerial view of the present University of Wisconsin Medical School buildings.

large, and in the recent epidemic of poliomyelitis an emergency was met in a magnificent manner.

Under the bequest of Mr. Michael W. McArdle, the University of Wisconsin received sums that, supplemented by Federal Public Works Association monies, made possible the erection of a fine laboratory for cancer research. This building was completed in 1940 and since that time the contributions of the staff of the McArdle Memorial Laboratory in this field have been most conspicuous.

This work has been vastly extended by legislative grants, subsidies from national foundations, and private bequests. Notable among the benefactions to this cause has been the Jonathan Bowman bequest.

Reflecting the University policy of state service the Medical School has welcomed the association of a number of closely allied state services. By its very nature the State Board of Health requires strong central laboratories. In 1903 legislative action established such a unit in connection with the University department of bacteriology. With the eventual separation of the several departments of bacteriology in the University the State Laboratory of Hygiene acquired its present title in 1911 and from that date its association with the Medical School became much more intimate. The Wisconsin Psychiatric Institute had its beginnings at Mendota in 1915. In 1925 it was moved to the University and, as indicated above, is currently housed in the Bradley Memorial Hospital. The services of these two important units to the public and medical profession of the state cannot be exaggerated.

The most important ancillary educational effort of the Medical School is the School of Nursing. This school was established in 1924 under the directorship of Helen I. Denne. In 1938 Christina C. Murray succeeded to this post. Some classroom space is afforded in the basement of the Nurses Dormitory. The remaining facilities are found in the State of Wisconsin General Hospital and Service Memorial Institutes. In the interest of economy and cohesion its staff is supplemented by the medical faculty. Three types of instruction are offered: the first leads to the Certificate of Graduate Nurse, the second toward the degree of Bachelor of Science (Hygiene), and a third to the degree of Bachelor of Science (Home Economics).

In 1937 courses in Medical and X-ray Technology were instituted in the Medical School and the State of Wisconsin General Hospital. These vocational outlets have answered a growing need. With the demand for physiotherapists, separate courses in Physical Medicine and Occupational Therapy were established in the Medical School in 1942.

Marquette University School of Medicine
MILWAUKEE

EBEN J. CAREY

Doctor Carey was appointed Dean of the Marquette School of Medicine in 1933. He was graduated from Rush Medical College in 1925, and now serves as Professor of Anatomy, in addition to his duties as dean.

Doctor Carey is a member of the American Association of Anatomists, the Radiological Society of North America, Inc., and is a fellow in the American Medical Association.

IN 1911 the Milwaukee Medical College and the Wisconsin College of Physicians and Surgeons, both of Milwaukee, were rated Class C by the American Medical Association. This rating meant that complete reorganization was considered necessary if the schools were to be acceptable to the American Medical Association and to most State Boards of Medical Examiners.

At this point Marquette University offered to conduct medical education on a Class A basis provided that both of the schools of medicine in Milwaukee were dissolved. On December 28, 1912, therefore, Marquette University purchased the property of the Wisconsin College of Physicians and Surgeons; and on January 25, 1913, similarly purchased all of the equipment of the Milwaukee Medical College, with its associated hospital and training school for nurses, and leased its land. The two student bodies were merged, the faculties were united, and the required full-time faculty members were obtained from Northwestern University, Harvard University, the University of Chicago, Western Reserve, and others of the foremost schools in the country. A library was begun when the University spent $15,000 for housing a collection of 3,000 volumes and 50 medical and scientific periodicals. An additional expenditure of $20,000 renovated the general and surgical laboratories. Entrance requirements were raised gradually (in order to work no injustice upon students who had already applied for admission) so that by the first of January, 1915, two years of premedical preparation, with a proper distribution of courses in science, languages, etc., were required for admission. These changes resulted in a reduction of the student body from the 267 who composed the student bodies of two Class C colleges, to 52, with a resulting financial deficit of about $25,000 a year. Marquette University nevertheless maintained the school at its high standard and even made other expenditures, such as remodeling the old dispensary building and purchasing new equipment for it at a cost of $7,000. This new dispensary was furnished at the request of the staff, and the University traditionally has been most willing to fulfill the requests of its medical faculty. The first dean of the school was Louis F. Jermain, appointed January 1, 1913.

Because of the integrity which Marquette University had manifested in abiding by its agreements with the American Medical Association and with the public in general, the School of Medicine came to the attention of the Carnegie Corporation, whose trustees offered to endow it with a third of a million dollars provided that an additional two-thirds of a million could be obtained from the communities which the school was serving. The important role which Marquette University played in the medical work of the Army and Navy during the first World War was partly responsible for the interest shown by the Carnegie Corporation. On the third of October, 1918, the campaign to raise this two-thirds of a million dollars was closed with the announcement that the fund had been oversubscribed. A Board of Trustees was appointed from among Wisconsin's foremost business and professional men; the curriculum was revised in the direction of higher standards; the library was increased by a thousand volumes; the herb garden was enlarged and many new specimens were added; and a history seminar was organized. At the same time 170 of the students of the school were in the service of their country.

On October 17, 1919, the School of Medicine held its first exhibit in the convention of the State Medical Society of Wisconsin. In the same year the practice of publishing in volumes reprints of papers produced by the faculty was begun. One year of internship was now required before a diploma was granted.

In 1920 the American Medical Association reexamined the school and rated it Class A. Its enrollment was now greater than it had been since the initial raising of requirements. A clinical laboratory was organized, and in 1920 the dispensary of the school was treating some thousands of patients annually.

Growth continued. In 1921 the school played a large part in the Tri-State Medical Convention. In the following year the buildings were renovated; the affiliation with St. Joseph's Hospital of Milwaukee was strengthened; new equipment was being purchased continuously; and the new laboratories of physiology now had been completed.

In 1923 again an exhibit was held in the convention of the State Medical Society, and this practice has been continued at all of the subsequent conventions. In the same year, the *Circle*, the honorary student scholarship society, was organized; it is one of the highest ambitions of every student to become a member of this society. The Alumni Association of

Marquette University School of Medicine.

the School of Medicine was incorporated in 1925. At this time many valuable additions of specimens and models were incorporated into the Marquette–Kircher Museum of Anatomy. The School of Medicine was made a unit in the Army Reserve 109th General Hospital in 1925. In this year also the Alumni Association held its first annual clinic, thus inaugurating an annual professional and social reunion which has grown in scope and importance each year.

In 1928 Bernard F. McGrath, a graduate of Harvard Medical School and a member of the staff of the Mayo Clinic, was appointed dean. He instituted added dispensary facilities for students and new methods of examination, and strengthened the faculty. Many other improvements in teaching and additions to the plant and facilities, together with a new library endowment voted by the Circle, culminated on the eighth of October, 1931, when the President of the University, the Reverend William F. Magee, turned over the first spadeful of earth on the site where the new School of Medicine was to be erected. This building, the Harriet L. Cramer Memorial, was dedicated on the fourth of January, 1933. It was made possible by a bequest of about a million dollars in an endowment from the great and public-spirited woman whose name the building bears.

When the building was designed, staff members from each department of the School of Medicine were invited to confer with the architects concerning the internal arrangements for their departments. It happens thus that each department is housed in offices and laboratories arranged according to the wishes of its own personnel. This plan, which was carried out in such a way that the architectural integrity of the building was not disturbed, enables each department to carry out its function with maximum efficiency. The building itself adjoins a similarly designed building for the Dental School, although the two institutions are distinct and independent educational units in organization and administration. Adjoining the site of the School of Medicine is a tract of land which is being reserved by the University for the expansion of the present building for further laboratory and library facilities.

On the twenty-first of September, 1933, Dr. Eben J. Carey was named dean of the Marquette University School of Medicine. About this time the alumni began to seek closer contact with their alma mater than they had enjoyed in the past, and the alumni organization now plays a very important part in increasing the endowment of the school, in taking part in professional and scientific activities held at the school, in building the Student Loan Fund, and in adding volumes to the library and equipment to the departments.

The School of Medicine presented an exhibit at the World's Fair at Chicago in 1934. A history of the Alumni Society was compiled. "Bedside Clinics," an annual publication, was inaugurated. A series of annual Memorial Lectures was instituted. By the end of 1935 the library had grown to number over 9,000 volumes. In this year, with the collaboration of the faculty, the students laid plans for the publi-

cation of a medical periodical to appear quarterly, entitled the "Marquette Medical Review," the first issue of which was published on the fifth of March, 1936. The "Review" has appeared regularly as scheduled ever since its inception. Its contents are written almost exclusively by the students and embody the results of their literary, historic, and scientfic research. This periodical is exchanged with most of the institutions and libraries not only of the United States but also of the countries of South America, Europe, and other parts of the world.

At this point it may be added that the Journal of the Biological Photographic Association is edited from the Department of Art and Photography of the Medical School.

The library of the Milwaukee Academy of Medicine was combined with that of the School of Medicine in 1939. With this increase, and with added facilities for the purchase of new books, the joint libraries number just under 40,000 volumes and, moreover, subscribe to almost 400 scientific periodicals published in all parts of the world. The library is endowed with three separate funds. Provision for the support of the library was especially made in the will of Harriet L. Cramer. Five other lesser endowments have been established recently. It was necessary to enlarge the library space by one whole story of the building in order to accommodate its increased content. A large and light reading room was provided for the students, and smaller individual rooms for faculty research. The Horace Manchester Brown collection of old and rare volumes, incunabula, and manuscripts has been given a special room and completed with a collection of old medical and surgical instruments, together with a few busts and framed prints.

The Marquette–Kircher Anatomical Museum contains nearly a thousand specimens and models, in addition to many thousands of charts, X-ray plates, lantern slides, and stereoscopic pictures. The Ramon y Cajal Pathological Museum holds over four thousand specimens of gross pathology and more than ten thousand of microscopic pathology, besides nearly a thousand stereoscopic transparencies, half a thousand each of lantern slides and roentgenograms, and hundreds of other objects such as preserved cultures of pathogenic bacteria, etc. The Museum on Bright's Disease constituted a part of the Medical School's exhibit at the Chicago World's Fair of 1933, and is complete from a portrait of Bright to actual specimens of kidneys preserved in glass.

Anatomical Dissecting Room at Marquette.

Pathological Museum at Marquette.

A technology course was added, and in 1937 the school was made a Naval Reserve Unit. At the outbreak of the war the School of Medicine collaborated with the war effort in the same way as did all her sister schools throughout the country. The ASTP and Navy V-12 programs were accepted at once and curriculum and schedules were arranged so that the accelerated program advised by the War Department could be adopted.

In conclusion, it is edifying to note the kind of relation which has existed between the School of Medicine of the University of Wisconsin and that of Marquette University. The eminent Charles R. Bardeen, then Dean of Medicine at Wisconsin, wrote,

"I believe that there are few people in Milwaukee or in the state who realize what an efficient medical school has been built up at Marquette in spite of limited resources, through the unselfish devotion of those engaged in administering the school and in teaching. . . Between the two institutions, there should be only that friendly rivalry which makes for better work, otherwise co-operation. I have felt that this co-operation exists at the present time. I have the utmost confidence in the ideals of those in charge of Marquette Medical School at the present time and I hope that thoughts of future clinical development of the University of Wisconsin Medical School, which I sincerely believe in, will in no way hamper individuals from giving liberally to the campaign for Marquette Medical School."

There are at present on the faculties of these two schools men who have gone from one to the other; there is an informal organization embracing exclusively the faculties of both schools, whose members meet socially and professionally to discuss any subject of mutual interest; and it is evident that the two schools of medicine in the State of Wisconsin are united in a common purpose for the advancement of medicine and medical education and the mutual benefit of both institutions.

Estate and Inheritance Taxes

Introduction

ESTATES of sufficient size are today subject to at least two taxes during the course of probate. One is the federal estate tax which is levied on net estates in excess of $60,000. The second is the Wisconsin inheritance tax which is levied on each interest in excess of the statutory exemption which passes by reason of the death of an individual. These exemptions are in varying amounts, the largest being $15,000 in the case of a widow.

The above two taxes do not take into account the growing trend toward multiple taxation by which is meant the taxation of the same property by two or more states. This trend is checked as between states which have reciprocal statutes. Under the terms of such statutes multiple taxation is avoided by the provision that one state will not tax the property of a nonresident from a second state which in turn has a similar law. The problem is substantial to an increasing number of estates and can greatly reduce the provision which one has made for his family or other beneficiaries, where such person owns property in one or more states outside of Wisconsin which has no reciprocity statute. Such states reach out and tax whatever they can of the property of a nonresident.

The 1941 federal Revenue Act greatly increased basic estate tax rates with the result that those taxes at least doubled on the first $100,000 of taxable net estate. The 1942 act did not increase rates but did contain important amendments which will affect many estates hereafter. These amendments are summarized below.

Federal estate tax rates vary from 3 per cent to 28 per cent on the first $100,000 of net estate subject to tax, and increase by degrees to a 77 per cent maximum for that portion of any estate in excess of $10,000,000. The increased rates have been effective since September 20, 1941, whereas the 1942 amendments hereafter discussed are effective only as to persons who died after October 21, 1942.

The only important action of the 1945 Wisconsin Legislature with reference to inheritance taxes was the reenactment of the 30 per cent emergency relief tax computed over and above the normal inheritance tax. The normal tax rate depends upon the relationship of the beneficiary to the deceased and upon the amount received, and varies from 2 per cent to 15 per cent of the amount over and above the exemptions given to the beneficiary. These basic rates are exclusive of the 30 per cent emergency relief tax which was reenacted as above stated.

Like other branches of tax law, those dealing with state inheritance and federal estate taxes are mounting both in their complexity and their rates. The points indicated below are not intended to be comprehensive or exhaustive, but rather to indicate to the physician, in broad outline, some of the general problems involved in those taxes, so as to aid him in planning his estate.

The subject of estate and inheritance taxes is treated in this issue because it bears with increasing directness on the long-term plans of the practicing physician. These taxes must be taken into account, for example, when a physician is making provision for the support of his family, the sale or other disposition of his practice, the collection of his outstanding accounts, and the termination of the partnership arrangement which he may have with one or more associates. The prudent practicing physician simply cannot disregard in these times the question of how his estate and his family will be affected by these taxes.

Closely related, of course, is the other problem of state and federal gift taxes, but since these deal with purely voluntary dispositions of surplus funds or other property, and are not, as such directly a part of the practice of medicine, that subject is not treated here. However, it is recommended that the physician ask his attorney to outline the problem of gifts and of gift tax liability for him, so that he may determine whether those laws have any special application to his personal situation.

Federal Estate Tax

The federal estate tax is based on the right of an individual to *give* away the property which he accumulates, as distinguished from the right on the part of his beneficiary to *receive* such property. Among the principal points of interest to the physician in connection with the federal estate tax are the following:

1. *Liability to file return.*—If the gross estate—that is, the total valuation of all assets before deducting debts, expenses of administration, taxes, etc.—is $60,000 or less, no estate tax return need be made by the executor or administrator of the estate of a deceased. If more than $60,000, such a return must be made.

2. *New Exemption of $60,000.* Until adoption of the amendments in October, 1942, the federal law has for a number of years provided an exemption of $40,000 of general assets which were not subject to estate tax and an additional $40,000 exemption of insurance payable to beneficiaries other than the estate of a deceased person. The 1942 amendment repealed the insurance exemption and increased the general exemption from $40,000 to $60,000. This

To make the article on "Income Tax Provisions Affecting the Medical Professions" more timely, it was published in the December, 1945, issue of The Wisconsin Medical Journal.

new exemption includes both insurance payable to the estate and insurance payable to beneficiaries other than the estate on policies on which the insured person has reserved the right to change beneficiaries, as well as other assets.

For the person who has little or no insurance, and whose estate consists of other property, the increased exemption will prove highly favorable. For the person who has $40,000 or more of insurance and in excess of $20,000 in general assets, the 1942 amendments will have the effect of increasing his estate taxes.

Example:

Valuation of gross general assets	$30,000
Amount of insurance payable to estate, or revocably assigned to others	45,000
Gross estate	75,000
Total of debts and deductions	10,000
Net value of estate	65,000
Amount subject to estate tax after deducting $60,000 exemption	5,000

3. *Powers of Appointment.* Each physician would do well at this time to read over his will and see whether it does not call for revision in the light of changed circumstances. One of the points to be noted particularly is the presence of a power of appointment in the will. By this is meant the conferring of authority on another person to designate the person or persons to receive certain of his property. By the terms of a 1942 amendment to the federal act all powers of appointment, except for those to very restricted classes of relatives, are taxable to the estate of the person to whom such power of appointment was given, *even though such latter person might himself have died without ever exercising the power.*

In other words, it is possible under the 1942 amendment for a physician by the phrasing of his own will to impose a heavy tax penalty on the estate of his wife, son, or anybody else to whom he may give a power of appointment, even though such wife, son, or other designated person never derived any benefit whatever from that power and never exercised it in his own favor or that of anyone else.

You should check this matter immediately with your attorney so that you may be sure to come within the exemption of the statute in the event you desire to continue the power of appointment in your will.

4. *Miscellaneous Amendments.* The 1942 federal amendments contain a number of other changes which may hold interest for the physician, one of which concerns charitable pledges founded on a promise or agreement to make a contribution or a gift, so long as the recipient is not an individual and is of a character recognized by the federal statute as being truly charitable. This would include such groups as churches, scientific and educational foundations.

Wills very frequently provide for a bequest of personal property or a devise of real estate to a certain person, under the further condition that if such person should die before receiving the gift, or should for any reason not accept the gift left him by the will, the property so given will go to a charitable organization. One of the new amendments provides that a person entitled to receive a gift by will may renounce or give up his claim irrevocably by a written statement filed prior to the time of filing the federal estate tax return, and that if he does so the property which he would otherwise have received is not subject to tax since it is to go to the charity rather than to him.

Still another of the new amendments provides that if an estate tax is not paid when due the wife or other beneficiary of the estate, including a person having the power of appointment, shall be liable for such tax to the extent of the amount of property which he has received from the estate.

5. *Irrevocably assigned insurance exempt.*—Insurance on the life of a deceased which was irrevocably assigned to beneficiaries other than his estate is wholly exempt from taxation if—

(a) The insurance was not assigned as a gift in contemplation of, or to take effect at, his death.

(b) The beneficiary paid the premiums on the insurance out of funds or his own which did not come to him from the insured either directly or by gift or trust established in his favor by the insured.

By the term "irrevocably assigned insurance" is meant the designation in a policy by the insured person of a person or persons as the beneficiaries of the policy without reservation in the insured of the privilege of changing the beneficiaries at any future date. This has the legal effect of vesting in the beneficiaries irrevocably designated all property rights to the policy.

A 1942 amendment provides that the possibility that a policy may come back into the hands of the insured person and be available to his estate does not destroy what is otherwise an irrevocable assignment.

6. *Joint interests taxable.*—Any property held by a physician and another, or others, jointly, is included in his gross estate to the extent of the physician's title or other interest in such property. Determination of the physician's *actual* interest where that varies from his *declared* interest is subject to technical rules which need not be detailed here. Thus if his *declared* interest as joint tenant in certain land acquired by purchase is shown by the deed to be one-third, whereas his *actual* financial interest is two-thirds, the land will be appraised in the inventory of his estate at two-thirds of its full value.

7. *New Accounts Receivable Rule.* From the standpoint of the physician one of the most important changes made by the 1942 Revenue Act was the abolition of the accounts receivable accrual rule under which all the uncollected accounts receivable due a physician at the time of his death were given

a valuation *both for income and estate tax purposes*, even though none of them were in fact collected at the time of his death, and part of them would never be collected.

The new change in the law provides that such accounts receivable shall not be accrued for income tax purposes at the time of death, but shall be treated as income when and as received by the estate or by some beneficiary of the estate. This is strictly a matter of income taxation, but because it is so closely linked with the cash provision which a physician must make when planning his estate, and because there has been confusion and misunderstanding in the past, the point is again emphasized here.

It should be emphasized that for estate tax purposes a net valuation is *still* placed on the accounts due a physician at the time of his death, just as was true before. The important change is that the income tax on the accounts is payable *only as the accounts are received* instead of being payable by the estate during the course of probate *irrespective* of whether received or not.

Wisconsin Inheritance Tax

The Wisconsin inheritance tax is based on the right to *receive* property from the estate of a decedent in contrast to the basis for the federal tax, above noted, which is on the right to *give*. The practical effect of a tax on the right to inherit, such as Wisconsin's, is that each legacy or other share in the estate of a deceased is subject to tax to the extent that it exceeds the statutory exemptions, and the beneficiary gets only the net amount. Thus if a bequest of $5,000 is left by will to a beneficiary, and the inheritance tax on it is $300, such beneficiary will receive only $4,700 from the estate, the other $300 being retained for payment of the tax. This result can be avoided by provisions in the will that designated gifts are to be paid in their full amount to those designated, the estate to pay the amount of the tax. Below are indicated several points which it is hoped will assist the physician in estimating broadly his liability under the Wisconsin inheritance tax law.

1. *Liability to file return.*—Unless it is apparent from the final account rendered by the administrator or executor of an estate to the probate court that the estate is nominal in value, or that the net amount of any share of the estate will fall substantially short of the exemptions allowed by statute, as indicated in paragraph 2 immediately following, every administrator or executor must make an inheritance tax return to the state department of taxation.

2. *Tax exemptions.*—The following amounts received from estates are exempt: $15,000 received by a widow from the estate of her husband; $5,000 received by a widower from the estate of his wife; $2,000 where the relation of the beneficiary to the decedent is that of child, parent, brother, sister, descendent of brother or sister, daughter-in-law, son-in-law, or a child adopted under certain conditions. A $250 exemption is allowed where the relation of the beneficiary to the decedent is that of uncle or aunt or the descendent of an uncle or aunt. An exemption of $100 is allowed where the relation of the beneficiary to the decedent shall be that of any other degree than those stated above, or he shall be a stranger in blood to the decedent.

3. *Insurance exemption of $10,000.*—Under a 1939 amendment, insurance up to $10,000 on the life of a decedent, payable to a beneficiary or beneficiaries other than the estate of the insured is exempt from inheritance tax. This exemption is in addition to that allowed those same beneficiaries if they should receive any of the general assets of the estate, as indicated in paragraph 2 immediately above.

Each beneficiary of such insurance, other than the estate of the insured, is entitled to a portion of the total exemption of $10,000 based on the ratio that the value of the insurance payable to him bears to the value of the total insurance payable to all beneficiaries other than the estate.

Example: Dr. Smith dies and leaves $10,000 in insurance payable to his estate and a $10,000 policy to each of his five children, or a total of $60,000. The $10,000 policy payable to his estate is not included within the $10,000 exemption above, and may be disregarded for purposes of its computation; $2,000 would be exempt on each of the five policies of $10,000 to each of his children, and a tax would be payable on $8,000 of each of those policies. The $8,000 subject to tax in each instance would be added to any other share of such beneficiary in the general assets of the insured's estate and only one tax assessed.

4. *Insurance payable to estate nonexempt.*—No insurance payable to the estate of the insured person is exempt from the Wisconsin inheritance tax. It is included in the general assets of the estate, and whether a tax will ultimately be paid on it will depend entirely on whether the share going to each of the beneficiaries of the estate exceeds the statutory exemption.

5. *Irrevocably assigned insurance exempt.*—Insurance payable on the death of any person which is irrevocably assigned to a beneficiary other than the estate of the insured, so that the insured retains no legal incidents of ownership in such insurance is exempt from inheritance taxation. By "legal incidents of ownership" in an insurance policy are meant the right of the insured or his estate to its economic benefits, the power to change beneficiary, to surrender or cancel the policy, to revoke it for an assignment, to pledge it for a loan, or to borrow on it against the cash surrender value.

The exception to this general rule would be an irrevocable assignment of insurance made by the assured in contemplation of his death, which would be included in his gross estate.

Further applying the statute, if an insurance policy were carried on Dr. Smith's life, even though his wife paid the premiums on the policy out of her

own income, the face amount of the policy would be subject to state inheritance tax after the doctor's death, if he had during his life retained any of the "legal incidents of ownership" in the policy as that term is above defined.

6. *Joint interests taxable.*—Any property jointly held by the physician and another or others is subject to tax to the extent of the deceased's declared joint interest in such property.

Example: Dr. Smith and his wife own as joint tenants a farm worth $20,000 at the time of the doctor's death. Dr. Smith's interest is computed as one-half of that valuation, or $10,000, in his gross estate, and that amount will be deducted from the $15,000 which will be exempt in the hands of Mrs. Smith as his widow.

Agreements of Lease and Locum Tenens

THE negotiation and signing of leases is an almost universal periodic experience for the physician. If he will observe the precautions indicated below, he may avoid disagreeable experiences and monetary loss.

A. OFFICE LEASES

A lease is a special type of contract and once general negotiations have been completed, the desirable and prudent policy is to have an attorney draft the instrument itself. This will often prove a much more desirable policy than for the physician to read over hurriedly, and perhaps without full understanding, the printed provisions and rules of a "form" lease, which is generally drafted for the owner's protection rather than for that of the tenant.

The law on the subject of relation of landlord and tenant is a highly involved one and contains a large number of rules. It is thus difficult to generalize those rules, and the effort here made in that direction is intended to *indicate* problems which may quite commonly arise, together with suggested solutions. It must be borne in mind that the remedy in a given case may hinge on the particular facts, or even on a single fact, and that the suggestions above made will have general rather than specific application.

Important Lease Considerations

1. Cancellation of lease by tenant for health or professional reasons. The physician may wish to leave the community, in which he is practicing, for reasons of health or because of a more promising professional opportunity elsewhere. But because his office lease requires him to pay to the end of the term, and no other tenant can be readily procured, he may feel he cannot afford to leave.

Remedy: A clause giving the physician tenant the privilege of leaving for reasons of health, or for professional reasons, may be inserted in the lease with the consent of the owner. Ordinarily, such a provision requires the payment of some additional rent after the physician moves or gives notice of moving, say for thirty or sixty days ahead, so as to compensate the owner against possible vacancy for that period. The owner might reasonably require that in the event of removal for professional reasons, such change of location must not be merely to a place in the same locality, but some specified distance beyond the locality. This and details of notice and causes for moving should all be carefully agreed upon in such a provision.

2. Cancellation of lease following death of physician. The ordinary lease does not terminate on the death of the tenant but is expressly made binding on the tenant's heirs, personal representatives and assigns. This has the legal effect of binding the estate on rental and other obligations. It would seem wise to give the personal representative of a deceased physician (his administrator or executor) the option of limiting or terminating the rental liability of the estate whenever, in his judgment, this should be done.

Remedy: Following is proposed phrasing to carry out this suggestion:

It is mutually understood and agreed between the parties hereto, that in the event of death of the lessee during the term of this lease, his executors or administrators shall have the option of either terminating the lease or reducing its terms to a month to month rental basis, such privilege to be exercised within 60 days after the executors or administrators qualify as such in proper court proceedings.

Written notice of termination given to the lessor, or his agent, pursuant to the above agreement shall terminate all liability on the part of the lessee's estate, his administrators, executors or heirs, for rents to be paid for future occupancy of the premises beyond the 30 days next following the service of the notice.

Any option to renew contained in this lease may be exercised by the executors or administrators of the lessee at the time and in the same manner as provided for the lessee himself, but renewal of this lease will not be implied from any failure of the lessee's representatives to act hereunder.

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3. Decorating of premises. Unless a lease otherwise provides, the owner may not be obligated to do any decorating of the exterior or interior of leased premises.

Remedy: Questions of decorating leased premises prior to occupancy and during the course of occupancy can easily be handled by appropriate provisions in the lease.

4. Destruction of premises. Leases frequently do not provide for the suspension of rent where fire or other casualty has rendered the premises partially or totally unfit for occupancy. Thus a situation may arise, in which the physician cannot con-

tinue to occupy the premises following a fire or other serious damage, or can, at best, only occupy them under great difficulty, and yet is compelled to continue full rent payments.

Remedy: The lease should provide that in the event the premises should become wholly untenantable by reason of casualty damage the physician either be immediately released from rental liability or be released following the expiration of a reasonable period required either for the rebuilding of the premises or for the substitution of office facilities in a form acceptable to him. Where premises have been made partially untenantable by reason of casualty damage the lease should provide for a proportionate abatement of rent. Thus if the premises are only 50 per cent usable, there should be a 50 per cent rental allowance until they are fully restored, but any percentage of nonuse over 50 per cent might well be considered as sufficient to excuse any rent payment.

5. **Heating and hot water facilities.** Unless a lease so specifies, the owner may not be obligated to furnish either heat or hot water, both of which are such essential items in a physician's office.

Remedy: Questions both of heating and the furnishing of hot water should be settled at the time negotiations are under way, and then should be carefully set out in the lease itself.

6. **Installations.** A physician may find that the premises he proposes to rent will require additional water and plumbing facilities, and also special gas and electric facilities. The three questions which arise in connection with such installations are: (1) Who has to pay for them initially? (2) Whose property do they become following installation? (3) Must they be removed or the premises restored at the termination of the lease? Such installations are generally costly, and these questions are therefore of substantial importance to the physician tenant.

Remedy: Wherever the plumbing, wiring, or other installations will permanently benefit the premises, the physician should endeavor to arrange that the owner pay so much of the installation cost as possible, and that he pay only the remainder. Wherever such installations are of such a character that they could be removed to other premises by the physician on the termination of his lease, he should reserve in himself the title to and right to remove such installations by terms of the lease itself. In the absence of such a provision, installations will ordinarily be regarded as affixed to the premises and, as such, a part of the real estate. This places title to such fixtures in the owner, and the tenant has no right to remove them on the expiration of the lease. Should the lease be for a period of only two or three years, a substantial investment would have been lost at the termination of that time should the physician be unable or unwilling to renew.

Where the tenant is permitted to remove such fixtures as he has installed, he would ordinarily be expected to restore the walls, floors and other affected parts of the premises to their original condition. This is a reasonable enough provision. Some leases, however, not only give the owner the legal title to such installed plumbing, wiring, etc., but also provide that at the owner's option the tenant may be required to restore the premises to their original condition on expiration of the lease, without being permitted to take away any of the fixtures for which he paid. The tenant should not permit such a provision in the lease.

7. **Military Service.** Until recently, the Soldiers' and Sailors' Civil Relief Act of 1940 did not extend its benefits to office space occupied by a person entering military service. Under the terms of an October 1942 amendment, the act has now been broadened to include space occupied for professional use. This point, which is of importance to every practicing physician who leases office space, is discussed on page 124 of the 1945 Medical Blue Book.

8. **Public liability coverage.** Many leases contain a clause under which the physician tenant assumes all liability which would normally accrue to the owner of the premises, as, for example, injury to a patient who might be hit by falling plaster in the physician's waiting room while keeping a professional appointment. The average public liability policy does not cover liability assumed under a contract by the tenant but, instead of this, commonly contains a clause substantially as follows:

> *"This policy does not apply to any liability assumed by the assured under any contract or agreement."*

The legal effect of such wording is that the physician is without protection under such a policy although he thinks he has coverage.

Remedy: First, examine the lease to see whether it contains such a provision; namely, that the physician tenant is responsible for any injury received by any person while on the leased premises, even though a defect in the building be its cause. Second, examine the public liability policy carefully. Third, if the policy contains an exclusion of any liability assumed by contract, the physician should then adopt one of the following two courses promptly: (1) arrange with the owner to change the lease provision under which he assumes such liability; (2) if he cannot have the lease modified, have the assumed liability covered by a specific endorsement to be added to the public liability policy.

9. **Renewal of lease.** No lease is automatically renewed unless it contains a specific renewal provision. All indications point to some increase in rental in the years immediately ahead, and the most practical way to hedge against increased rental is by timely provision in present leases or in leases which may hereafter be signed.

Remedy: If the physician is now under lease, it would be well for him to negotiate with the owner of the premises for a renewal option at this same rental. This provision could be added by mutual consent to the existing lease and would take effect on its expiration, if the option were exercised by the

physician according to its terms. Ordinarily, such an option provides that the tenant may renew for an agreed period, at an agreed rental, by giving notice in writing of his intention to do so a certain number of days or months before the present lease expires. Those entering into leases hereafter would do well to include such renewal provisions.

10. **Repairs and upkeep.** The average responsible owner of office space will wish to keep up at least the exterior of the premises so as to prolong its life, minimize fire insurance rates and for other prudent reasons. Such owners are not necessarily willing to keep up the interior of the premises, however. Many leases go a step further and provide that all repairs of any nature which become necessary during the course of a lease are to be at the expense of the tenant. Thus, a physician might take over premises which were old or run down and have to replace such expensive items as the roof, floors, stairs, plumbing, heating plant and wiring during his occupancy.

Remedy: The prospective physician tenant should first make careful inspection of the premises he intends to lease, and come to immediate terms with the owner as to the condition in which they are to be put before he begins occupancy. He should then provide in the lease so far as possible that exterior repairs, such as painting, replacement of rotted boards or steps, or of the roof, be at the owner's expense. A still further provision might well be that repair or replacement of any substantial part of the premises during the lease was to be the obligation of the owner where such repair or replacement was due to ordinary wear and tear rather than to the negligence of the tenant. Still another prudent provision is that all structural repairs, which should include foundations, walls, floors, stairs, and roof, are to be the obligation of the owner rather than of the tenant. These provisions have particular importance where the physician is going to occupy old or outmoded premises.

11. Subleasing. Unless a lease makes provision for subleasing of the premises, the tenant has no rights whatever in this respect. A physician called into military service might find a highly desirable fellow physician to take over his practice, but he would be helpless in the matter unless the owner approved the subleasing. The same is true in the case of the physician who might wish to leave a community for reasons of health or because of an opportunity elsewhere.

Remedy: Provision should be made in the lease permitting subleasing of the premises after written notice to the owner. The provision permitting the physician to sublease should be as broad as possible, since he might not always be able to find a physician successor. At the very least it should permit him to sublease the premises to another medical practitioner.

12. It is recommended that where the landlord will agree, a clause be included in the lease which provides substantially as follows.

It is mutually agreed between the parties hereto that for the period of 6 months following the termination of this lease by its own terms or by the agreement of the parties hereto, to terminate it prior thereto, and where the tenant moves to offices within the same building, the landlord may not lease the tenant's former quarters to another engaged in the healing arts without the tenant's permission.

B. LOCUM TENENS

In the case of many of the physicians called into the service of our country, the responsibility of continuing medical service for the community and of maintaining the professional establishment will be of major concern. The State Medical Society holds itself ready to be of assistance to its members in this problem at any time.

In those cases where a locum tenens is secured, the Society urges that the arrangements be confirmed by a written contract, drawn with the assistance of a local attorney. In arriving at the terms of such an agreement members should consider these fundamental points:

1. *Licensure.*—The locum tenens must be licensed in Wisconsin as one entitled to practice medicine and surgery, with his license filed in the county in which he resides. He should be a member of the local and State Society as a further assurance of his ethical standing and abilities.

2. *Staff privileges.*—Association on the hospital staff, where necessary, should be arranged. The locum tenens should be apprised of the conditions necessary to a continuation of this association, and his compliance with them should be a continuing condition of the contract.

3. *Malpractice liability.*—Malpractice insurance should be maintained by both parties under all circumstances.

4. *Partners, independent contractor, or employe.*—One of the most important matters for decision is that of determining the relationship under which the locum tenens is to assume management of the office. Your own attorney can best describe the practical aspects of this problem. It is sufficient to say that there is a real distinction between these with respect to liability of the principal party for the acts of the locum tenens, and with respect to his power to bind or otherwise obligate his absent confrere. In deciding this relationship, consideration must necessarily be given to the extent the locum tenens is to control the practice. For example, may he move the office acting upon his best judgment alone? Or may he make such purchases to the office account as his judgment dictates? Are the costs of operation to be a joint burden, and in any event, what are they?

5. *Financial arrangements.*—Whether the locum tenens is reimbursed on a salary or drawing basis,

arrangements must be made with respect to handling withdrawals, the financial records to be kept, collection policy and obligations of locum tenens with respect to accounts receivable of the physician. In this connection note "Fee Splitting," page 48, and particularly "The Amended Soldiers' and Sailors' Civil Relief Act," page 123 of the 1945 Medical Blue Book.

Physicians and their attorneys are also referred to the article and opinions of the attorney general relative to division of fees between physicians, appearing on page 48.

6. *Locum tenens to give entire time.*—As an essential provision of the contract, provision should be made with reference to the amount of time that the locum tenens is to devote to the practice. Is he to give his entire time and not to engage in any business which would detract from his abilities to serve the community professionally?

7. *Costs of operation.*—If the salary or drawing arrangement with the locum tenens is to be based on the percentage of net income after payment of operating costs, items of costs should be specified so nearly as can be determined. If the physician should own his own office it is only proper that a rent basis for use of the office be established, and such items as light, heat, wages, insurance, supplies and equipment and the like should all be taken into consideration.

The physicians must likewise determine their policy with reference to accounting for collections for services rendered prior to execution of the agreement by the reserve officer. Are these to be considered income under the contract or are they excluded?

8. *Restriction on practice after termination of agreement.*—Wisconsin courts recognize the validity of clauses restricting practice after termination of a contract of employment. Your attorney may refer to the cases of *Eureka Laundry Company v. Long*, 146 Wis. 205, and *Madson v. Johnson*, 164 Wis. 612. The test is whether such a clause is in itself fair and reasonable and necessary for the proper protection of the professional interest involved. A frequent provision reads that the assistant may not maintain an office or hold himself out for practice in the city or within a reasonable area surrounding the city for a period of five years after termination.

9. *Arbitration of disputes.*—A clause may be inserted in the contract providing that in the event of disputes the matter may be referred to an arbitration committee of three, one to be selected by each party to the contract, the two so selected to select a third. The decisions of such an arbitration committee are ordinarily binding under the Wisconsin statutes.

10. *Termination.*—A provision for termination of the contract should be made. At the option of the party a definite date may be selected or termination can depend upon the time when the absent associate returns, or may be of indefinite duration, and terminable upon sixty or more days' notice. In any event it should be stated that failure on the part of the locum tenens to carry out in good faith the provisions of the contract should be cause for termination without notice.

11. *Miscellaneous matters.*—Other matters which a physician may desire to pass upon may include questions concerning the handling of bank accounts, power of attorney with reference to writing checks and the handling of certain business and personal matters of the absentee member, as well as the form of stationery, billing head, prescriptions, liquidation after termination of the agreement of accounts receivable arising during the operation by the locum tenens of the practice, care and replacement of medical instruments and the like.

* * *

The State Medical Society is most willing to cooperate with its members and their attorneys in the preparation of these contracts to meet the varying need of special circumstances and of the communities. If the physician is already in partnership, but a locum tenens is still necessary, the arrangement should be among all of the parties and the same applies even though the physician going into service is employed on a salary basis at the present time but wants to protect his particular practice.

PHYSICIANS AND THE PHARMACY LAW

The sale, compounding and dispensing of drugs, other than narcotics, are governed by the provisions of chapter 151, Wisconsin statutes, entitled "Pharmacy." This defines the practice of pharmacy and sets forth the requirements of registration and other regulations of those who practice in this field.

The definition of "drugs" is very broad. Included are all articles intended for use in the diagnosis, cure, mitigation, treatment and prevention of disease, together with articles recognized in the official pharmacopoeias.

It is expressly provided in section 151.04 (3) that this chapter shall not interfere with the dispensing of drugs, medicines or other articles by physicians. The effect of this provision is that physicians are not governed by this law in so far as they dispense or compound drugs for their own patients or fill an occasional prescription for another physician. However, they must not fill prescriptions for others *as a business*. See 3 Atty. Gen. 555; 16 Atty. Gen. 722. A physician who desires to engage in the business of pharmacy must comply with the provisions of the pharmacy law just as must the pharmacist.

This chapter of the statutes has nothing to do with narcotic drugs, their definition or use. For information on this field see "Narcotic Laws," page 81.

Fee Splitting

BY STATUTE enacted in 1913, and strengthened in 1915, fee splitting by physicians is prohibited, even between physicians taking part in the same operation. *Each physician must render his bill direct to the patient.*

Shortly after the passage of this law, Attorney General Walter C. Owen, later a member of the Wisconsin Supreme Court, was called upon to give his opinion with respect to its interpretation and general effect. The important questions asked and his answers are summarized below. For a more complete discussion see 3 Atty. Gen. 218.

1. *Under the law as it now stands, can a surgeon, not a member of the regular staff of a hospital, operate at such hospital for a stated fee for the institution and let the hospital collect the surgical fee from the patient according to his ability to pay along with other hospital fees; the hospital paying the surgeon the fee agreed upon, whether larger or smaller than the fee charged the patient by the hospital, or must the surgeon, under the circumstances, charge the fee for the operation direct to the patient?*

While the law does not specifically make it an offense for a hospital to employ a surgeon who is not a member of its regular staff to perform a particular operation under an arrangement that the hospital make its charge to the patient for such operation or treatment and that it make its charge for such surgical services irrespective of the amount paid by it to the surgeon, yet it would seem that the evils incident to such a practice would be as great as in the case of fee splitting between two physicians or surgeons.

2. *Where a surgeon operates at a hospital in which he has a financial interest, or in which he is part owner or sole owner, but conducts the business in the name of the hospital, must he make a separate charge for operation or may the whole charge be made by and in the name of the hospital?*

The hospital may employ a physician or surgeon upon salary and then make a contract with the patient to furnish him both medical or surgical treatment and hospital service. If this is done, the entire charge could be made in the name of the hospital. If, however, the physician or surgeon is not paid a salary, but charges separately for each treatment or each operation, the safer practice is to make the charge for medical services direct to the patient and let the hospital make its charge separately to the patient.

3. *Can a surgeon who is not a resident of the city where the hospital is located and who does not hold himself out as a member of the staff of such hospital operate at such hospital and make a charge direct to the hospital under the existing law?*

4. *Where a country physician engages a surgeon to assist him in an operation at the home of the patient or at the residence of the country physician, can the surgeon make his charge direct to the country physician engaging him or must he make a special contract with the patient?*

5. *Under these conditions, can the country physician make the contract with the surgeon or must the contract be made directly with the surgeon by the patient?*

The attorney general's opinion answered all three of the questions with the statement that the safer practice under any of the above circumstances is for the surgeon to make his charge direct to the patient, or to phrase it otherwise, for the consulting surgeon to make a contract with the patient which is separate from that between the original physician and the patient.

6. *Is a physician who brings a patient to a hospital for an operation or to a surgeon for an operation entitled to a fee for assisting in such operation or for time spent in accompanying the patient to the hospital or place of operation?*

7. *Can a surgeon charge a regular fee for operations to a physician, including fee for operating room, dressings, anesthetic, etc., irrespective of the ability of the patient to pay, and the physician in charge of the case collect his fee, including such operating fee as he thinks right, the surgeon performing the operation doing the work for and on contract with the physician?*

8. *If the surgeon or hospital charges a regular fee for operation to physicians, must the same fee be charged to patients who come for operation not accompanied by their physician, or can the surgeon or hospital make a charge suited to the ability of the patient to pay?*

In each of these cases the attorney general answered that the physician's and surgeon's charges should be made *direct* to the patient and that no part of the fee received by the surgeon or hospital should be paid to the physician advising the operation or treatment.

In 1935 the attorney general reiterated the conclusions given above in an opinion in 24 Atty. Gen. 580.

The practice of fee splitting has been widely criticized in the profession. For example, the American College of Surgeons has as a part of its requirements for the standardization of hospitals the adoption by each hospital of a resolution against the practice joined in by all physicians who have hospital privileges. Fee splitting is unreservedly condemned, and a hospital in which this practice is known to exist cannot secure or retain a place on the approved list.

Malpractice and Malpractice Suits

THE Wisconsin statutes provide that complainants in personal injury actions must give notice of their claim within two years after the "happening of the event" causing the damage claimed, unless they have begun action by service of summons and complaint within the same period. Section 330.19 (5). The Wisconsin Supreme Court has held that no matter whether a cause of action based upon malpractice is predicated upon a tort (wrongful act) or contract (breach of agreement) liability, the action is essentially one for personal injury and falls within this particular statute. See Frechette v. Ravn, 145 Wis. 589; Klingbeil v. Saucerman, 165 Wis. 60. This is likewise true although the action may be one for loss of services, nursing and medical expense. See: Shovers v. Hahn, 178 Wis. 615. Our Supreme Court has also held that an infant is not excused from complying with this statute. Hoffmann v. Milwaukee Electric, 127 Wis. 76. Thus it follows that the provisions of the statute are applicable to individuals incapacitated by reason of insanity or a similar cause.

But if the statutory notice is given by those incapacitated by reason of infancy or insanity, the ordinary statute of limitations is extended. In the case of infants, the statute is extended until they reach the age of twenty-one years. If the individual is insane, the statutory period of limitations will be extended five years, unless he recovers within the six-year period. If he recovers after the ordinary period of limitations has expired but before the eleven-year period has expired, he must bring his action within one year after the disability ceases.

In order to protect himself properly in event of a malpractice claim, certain routines should be followed by every physician. (In this connection see also page 52 of this *Journal.)* These routines may avoid unmerited claims arising through misunderstanding or precipitated by some thoughtless remark. In *The Wisconsin Medical Journal,* 27:573–575 (Dec.) 1928, certain precautions were suggested, and their substance is restated and somewhat augmented here, to help in avoiding malpractice actions:

Causes For Misunderstanding

1. Medicine is a science, but its proper application is largely an art. It is unwise to make unnecessary positive statements, particularly in early diagnosis or treatment in the broad field of human ills. When you say, "It is nothing but a cold; take these, go back to work and forget it," and subsequently it is found that the patient had incipient tuberculosis at the time he saw you, he is sure at least to resent your too-positive attitude if nothing more.

2. Few of the laity understand that an exact anatomic alignment in a fracture is not usual or necessary; that you are trying to attain it but that you are primarily interested in the functional result. When this is not explained and the patient subsequently sees an x-ray film showing only a fair anatomic result, who is to blame him if he fears he has had poor treatment? Frankness in explaining at least something of this to "fracture patients" is urged; then they will at least appreciate the difficulties that beset the paths of the best of men and will be thoroughly satisfied to find a good functional use restored.

3. The physician who promises quick results and fails to attain them frequently finds his patient seeking another physician.

4. Attorneys frequently say that street corner advice is worth just what one pays for it, yet it occurs with a fair degree of frequency that an attorney will ask a physician for street corner advice on a supposed course of treatment. Be careful what you say for he may be trying to arrive at conclusions whether a client has a real malpractice case. What he tells you will likely be but one side of the case and when all is known to you, your first opinion may be reversed.

5. In these days of compensation insurance a new cause for misunderstandings between physicians exists. It is an everyday occurrence for insurance carriers to demand that their physician see the insured. Such physician may occasionally make a report which is critical of the family physician and the insurance company may use this report to demonstrate to the claimant that his period of recovery was prolonged by the treatment of the family physician and that the company could not be expected to pay for the entire period of recovery. Again it is suggested that the second physician be sure he is in possession of all the facts before he makes a report critical of the family physician. If the family physician did his work carefully and exercised the same degree of skill as other practitioners in the community he will not be found guilty of malpractice even though better treatment might have been had in a distant, large hospital with more adequate facilities.

6. When a patient does not pay his bill, and the ability to pay appears to exist, many physicians turn the bill over to a collection agency which may start suit in a physician's name. The man who does not pay his just debts within a reasonable period of time when ability to pay exists, is frequently not a man of honor or character. Such a man may bring a counterclaim alleging malpractice as a means of blackmailing the physician into dropping the original action for collection of fees. Indeed, records show a fairly large percentage of malpractice suits are begun as counterclaims rather than as original actions. The understanding physician, appreciating the danger in counterclaims on the part of the unscrupulous, will watch carefully that bills of such persons are not pressed unduly until after two years have passed following the last treatment. This generally

means an added delay of but a few months and is a wise precaution when dealing with the type of people mentioned. After two years, malpractice is outlawed, but the statute of limitations still allows four years more in which to collect the debt.

7. No physician should pass over a case of definitely suspected fracture, dislocation or foreign body without advising roentgenograms to make certain the diagnosis, if it is impossible by the unaided senses to exclude these conditions. Failure to give such advice may lead to a malpractice suit.

8. The law does not require you to respond to a call by anyone who applies. But after you have once accepted employment, you assume responsibilities with respect to attendance that continue throughout employment. If you yourself desire to terminate those responsibilities, you may,—provided you give reasonable notice, in view of the condition of the patient, as will permit the patient to employ another attendant. This is a general rule of law; its applicability will vary as to each case.

Routine to Be Followed

Certain precautions should be followed as a routine if a physician desires to take every precaution to avoid malpractice actions.

1. Every roentgenogram should show the patient's number, the date, and at least the initials of the operator. The patient's record should show clearly the number of roentgen ray exposures.

2. In the case of fluoroscopic examinations the examiner should by all means note on the patient's record at the time the length in time of examination under the rays and the setting of the machine.

3. Do not put your faith in "fool-proof" apparatus. Have your equipment, such as your roentgen ray and fluoroscopic machines inspected regularly, for the assurance of the maker is no protection to you if something goes wrong.

4. Take no roentgenograms; do no fluoroscopic examinations without noting on the record the patient's statement as to when he was last exposed. If the patient is a "traveler," he may be burned through multiple exposures.

5. In fracture cases take a roentgenogram routinely on the day the patient is released. Besides providing you with the opportunity to explain functional versus anatomic results, you have evidence to prove the condition of the patient when released. Then if the patient has a subsequent accident, he cannot substantiate a claim of nonunion when released.

6. If your patient does not accede to roentgenography you have advised, or desires to leave the hospital before you think it wise, protect yourself against what might happen by reducing your advice to writing and handing a copy to the patient in the presence of at least one and preferably two witnesses. A written statement, signed by the patient in the presence of witnesses, refusing permission for use of roentgenography by you, or further hospitalization, is preferable. Following such procedure is of immeasurable value in event of future litigation.

7. It seems hardly necessary to state that in full records lies your greatest protection. Such records, made at the time, are the best evidence in court of conditions you found and treatment you advised. If your patient is not following your advice, be sure to make note of that at the time.

8. The importance of obtaining consent in all procedures involving operations or autopsies must never be overlooked. Neither good faith, patient welfare, nor good medical practices will stand alone as a defense against failure to secure consent, except only in those cases where an emergency makes it impractical for a physician to confer with the patient, or his guardian. See: Throne v. Wandell, 176 Wis. 97.

Burden that of surgeon.—While it is probably routine in all well regulated hospitals to secure a written consent from a patient about to undergo an operation, it must not be understood as any the less the surgeon's responsibility. And while oral consent is sufficient, difficulty of proof as to the fact that it was given condemns this procedure as insufficient protection.

Extent of consent.—A physician authorized to perform a specific operation acts at his peril in performing another or different one; nor, apparently, is he authorized to perform a more extensive and involved operation than that authorized. In all cases the consent should be sufficiently broad to include any procedures whether anticipated or not which may confront the surgeon at the time of operation. Consent must be obtained without fraud, and thus it is the safer policy to explain that sometimes unanticipated conditions or complications arise, so that, for the patient's welfare, the physician should be authorized to deal with them as they may arise.

Who may give consent.—Under ordinary conditions, and except in the emergency case as noted elsewhere, the person operated upon, if not a minor nor incompetent, may give his consent for any lawful operation. In the case of minors and incompetents, only those in the position of legal guardians are empowered to give such consent. The mere fact that a relative such as a brother endeavors to authorize an operation is insufficient, unless legal authority to do so exists.

Autopsy.—Consent is of equal importance where an autopsy is to be performed, and if it is desired to remove organs or specimens, the consent should so provide. The Wisconsin Supreme Court, in the case of Koerber v. Patek, 123 Wis. 453, held that—

> We can imagine no clearer or dearer right in the gamut of civil liberty and security than to bury our dead in peace and unobstructed; none more sacred to the individual, nor more important of preservation and protection from the point of view of public welfare and decency; certainly none where the

law need less hesitate to impose upon a wilful violator responsibility for the uttermost consequences of his act. We recognize, of course, that public welfare may and does require governmental control in many respects for protection of life and health of the people, and for discovery of crime connected with the death of a person, and to such interests the private right is subservient so far as necessary. Upon this ground rest cases of autopsies upon dead bodies under public authority, and to satisfy police regulations for ascertainment of cause of death.

Dr. W. C. Woodward, recently resigned director of the Bureau of Legal Medicine and Legislation of the American Medical Association, has pointed out that, subject to the legal rights of coroners, the right to control and custody of a dead body vests primarily in the surviving spouse, if there is any, and if not, in the next of kin in order of their consanguinity.

In the Koerber case, cited above, the Wisconsin Supreme Court also held that—

In absence of any surviving spouse, situations become subject to such complications that it probably is not wise, if proper, to attempt to declare general rules beyond the case actually presented. Suffice it to say that the duty and right of the parent toward the body of a minor child dying a member of his household, or of the adult child toward a widowed parent, either a member of the child's family circle, or not a member of any other, seems too clear to warrant discussion.

And while Wisconsin has not yet stated any further rules, Doctor Woodward suggests that as a practical matter: "Generally it will be found that some one of a given group will be at the place of death and will assume charge of the body, and it is to such a one that application will generally be made for permission to perform an autopsy. Almost universally, such consent is recognized as valid by other members of the group; but even if it should not be, the dissenting members would have difficulty in proving they had suffered damage by any supposed trespass on their rights."

However, it is only prudent to suggest that where there is doubt, great care should be exercised, and the advice of a local attorney sought. Even where the autopsy is performed at the request of a coroner, the physician is protected only when the coroner properly has jurisdiction of the body. Generally speaking, that means in Wisconsin either that the coroner must have ordered an inquest—on his own motion or at the request of the district attorney because there is good reason to believe that murder or manslaughter has been committed—before asking the doctor to perform the autopsy, or that a cremation of the body is planned and in the coroner's judgment an autopsy is warranted. When the physician is in any doubt as to the coroner's authority to authorize an autopsy, he would do well to check first with the district attorney and then with his own attorney on the question of the coroner's proper jurisdiction.

Character of suit.—Physicians generally understand that under the Wisconsin law, if a malpractice suit is not begun within two years after the happening of the event upon which the cause of action arose, proper notice must be given. The Wisconsin court has held that this is true whether the action be one in behalf of a minor, and whether based on breach of contract or negligence. But it is not clear whether the same law applies in the case of autopsies without consent. An action involving an unauthorized autopsy may be predicated differently, and not come within the statutory contemplation of an action arising out of a personal injury.

Other examinations; treatments.—It must be pointed out that many statutes come into play in connection with specific matters of examination and treatment. With these the physician is generally well acquainted. For example, authorization for treatment may be secured from the employer in workmen's compensation cases, but this does not release the patient's right to control, even though at some possible cost to himself, the question whether he shall or shall not receive some particular treatment. Yet even this may not be the right of the patient with venereal disease. The law becomes more complex, not more simplified, with the extension of legislative programs affecting the public security and welfare; but in all this the physician must keep in mind the general rules that govern the patient's welfare and his personal relationship to him.

For a more detailed treatment of the problem of consent to autopsies see the article entitled "Coroners and Autopsies," page 79.

9. If your operative reports are typed, read them carefully and sign your name in full. Do not just initial typed records. Never sign hospital operative records in blank to accommodate the hospital.

10. In the delegation of certain duties or functions to a technician, care should be exercised that such functions are those which may be called mechanical or ministerial and require the exercise of no judgment or discretion by the technician properly that of the physician.

The Case of Threat

Assuming that some day you are given a summons in a suit, or a suit is threatened, these pointers may be helpful:

1. Report the suit or threat to your insurance company *at once.*

2. You may be invited to call on the patient's attorney to "avoid" a suit. Let your attorney do that for you.

3. Tell your own attorney all the facts even though some do not reflect credit on your judgment. He cannot help you if you "hold out" on him.

4. Do not be offended if a friend of yours is going to testify for the plaintiff. Better a friend who will give you a square deal than a quack whose testimony is purchasable.

5. Be careful of too positive statements. Tell what you know in terms the jury can understand and admit that you do not know everything in medicine. When the plaintiff's attorney gets you to making one wholly positive statement after another he is soon apt to discredit your entire testimony by showing that authorities do not agree with some two or three statements and q. e. d.—you are "all wrong."

Malpractice Liability of Selective Service Examiner and of Physician in Service

A physician examining for a local selective service board and a medical officer in the armed forces of the United States is under legal duty to exercise the same degree of care, skill, diligence, and professional ability as would be expected of him in the care of patients in civilian life. The civil liability of a physician who acts for a selective service unit, or that of a physician in active military service, is in no way modified or diminished because his services may be performed or treatment rendered in connection with the defense needs of our government. This subject was well discussed in an editorial appearing in the September 13, 1941, issue of *The Journal of The American Medical Association*, which was in turn reprinted in the August, 1942, issue of *The Wisconsin Medical Journal* beginning at page 674.

The physician leaving for military service who is a member of a partnership, or who has made arrangements with some other physician to carry on his practice, should most certainly continue in force his malpractice insurance. His need for this form of protection is if anything greater during his absence.

As for the physician who has closed his office and made no arrangements for the continuation of his practice, the inclination may be strong to cancel his malpractice policy. However, this could be short-sighted economy, and it is recommended to the physician in the service of the armed forces of the United States that he continue his malpractice policy in force at all times. It is suggested that in any event a physician notify his insurance carrier of the fact of military service as soon as he enters upon active duty.

Every malpractice action undermines the confidence of the public in all physicians, and it is said that a dozen new suits are commenced based upon the publicity of a new case. You are your brother's keeper in maintaining a justified public confidence. Let no improper act of yours lead to a betrayal of that trust.

Statutes Relating to Producing Abortion or Miscarriage; After-Treatment and Patient Records

WISCONSIN has two statutes of which the first deals with the offense of causing abortion and the second with miscarriage. These statutes are printed here in full.

340.16 **Manslaughter, second degree.** Any person who shall administer to any woman pregnant with a child any medicine, drug or substance whatever, or shall use or employ any instrument or other means with intent thereby to destroy such child, unless the same shall have been necessary to preserve the life of such mother or shall have been advised by two physicians to be necessary for such purpose, shall, in case the death of such child or of such mother be thereby produced, be deemed guilty of manslaughter in the second degree.

351.22 **Producing miscarriage.** Any person who shall administer to any pregnant woman, or prescribe for such woman, or advise or procure any such woman to take any medicine, drug or substance or thing whatever, or shall use or employ any instrument or other means whatever, or advise or procure the same to be used, with intent thereby to procure the miscarriage of any such woman shall be punished by imprisonment in the county jail not more than one year nor less than six months or by fine not exceeding five hundred dollars nor less than two hundred and fifty dollars, or by both such fine and imprisonment in the discretion of the court.

Note that the section relating to miscarriages (a lesser offense) does not contain an express exception for the necessitous circumstances.

After-Treatment

The position of the physician called to treat a patient suffering from the results of an intended and incomplete abortion is a difficult one, and may be precarious as well. Not infrequently the abortionist merely starts the abortion, advising the woman to consult her own physician for all future care. If the woman dies, suspicion may well turn to those near at hand, and the innocent physician may find himself involved in unfortunate publicity as a result of his attendance on the patient at the time of death.

The most satisfactory course would involve the patient's complete disclosure of the facts to the proper authorities, but this is often difficult, if not impossible, of accomplishment. The woman obviously wishes to conceal her condition and its cause, and not infrequently does so until death. While the physician may properly urge such disclosure, he is not himself burdened with that responsibility for he must be ever mindful of those principles which make the welfare of the patient his chief concern.

When a physician is confronted with this type of case, he can, and should, insist that at least one other physician be called in before treatment is given. Preferably, and for obvious reasons, the consulting physician should not be one associated with the

attendant physician. Their joint testimony as to the woman's condition would almost invariably negative the charge that any operation performed in the course of treatment was itself an abortion.

In an emergency case, when no other physician is available, it is proper to insist upon the patient signing a written statement, in the presence of witnesses, if possible, reciting the facts with reference to the performance of the abortion, including the name of the abortionist—such statement to be made with the understanding that the physician may use it in event of his needing it for his protection.

In State v. Law, 150 Wis. 313, a physician called to treat a woman after an abortion refused to take charge of her unless she made a full statement concerning the abortion, which he insisted upon for his own protection and to enable him to institute proper treatment. The Supreme Court of Wisconsin said: "It was a very proper request for him to make under the circumstances." Thus there is judicial recognition, by the highest court in Wisconsin, that it is proper for a physician to take precautionary steps to protect himself in such a situation.

Treating the Sick in Wisconsin

Zealous in guarding the sick, and appreciative that the interest of the public health is always the foremost consideration, Wisconsin through its legislature and its courts has accepted the doctrine that to treat the sick is not a right but a privilege—a privilege that must be guarded carefully in the interest of the public. The material presented here is particularly designed for the information of those seeking this privilege in Wisconsin, as well as to provide those who have already secured that privilege with basic information relative to their particular practice and its authorized scope.

For rules and procedure in filing application for licensure as prescribed by the State Board of Medical Examiners, physicians are referred to the secretary of the Board, Dr. C. A. Dawson, River Falls, Wisconsin.

THE BASIC SCIENCE LAW

General

IN 1925, at the request of the State Medical Society of Wisconsin, the Wisconsin Legislature enacted the Basic Science Law, being the first state to do so. The majority of the states now have laws similar in purpose and effect. The Basic Science Law, which is a part of Chapter 147 of the Wisconsin Statutes, is appropriately named because it enumerates not alone the basic qualifications imposed upon those who would treat the sick, regardless of their method or system of doing so, but because it is also the basic structure upon which the health laws of Wisconsin are predicated.

The Basic Science Law does not authorize one who has successfully passed the examination to engage in any form or manner in caring for the sick. The law is intended only to afford reasonable certainty that, in the basic sciences of anatomy, physiology, pathology and diagnosis,[1] those who treat the sick in Wisconsin possess the minimum qualifications.

The Basic Science Law provides that no person shall treat, or attempt to treat, the sick unless he has a certificate of registration in the basic sciences, recorded with the county clerk of the county in which he resides.[2] But this alone does not permit a registrant to treat the sick. He must be otherwise licensed.[3] No examining board for any branch of treating the sick may license, register or admit to its examination any applicant unless he first presents a certificate of registration in the basic sciences, with the exceptions noted in the paragraphs immediately below.

Specifically exempt from the operation of the Basic Science Law are commissioned surgeons of the Army, Navy and federal health service,[5] registered nurses,[6] dentists,[7] optometrists,[8] and persons practicing Christian Science or others administering to or treating the sick by mental or spiritual means.[9] Medical or osteopathic physicians of other states or countries in actual consultation with resident licensed practitioners,[10] persons gratuitously prescribing and administering family remedies or rendering treatment in an emergency are likewise exempted.[11]

The attorney general has ruled that masseurs are not required to qualify under this law, since their licensure provisions impose what amounts to a basic science examination in the limited field of practice of massage and hydrotherapy.[12]

All persons who, prior to February 1, 1925 (the effective date of the Basic Science Law), were not registered or licensed to treat the sick but, on that date, were lawfully treating the sick in Wisconsin

were granted the opportunity of being registered upon application to the board.[13] Thus, all persons lawfully treating the sick in Wisconsin, other than those above enumerated, must possess a basic science certificate or its equivalent.

Definitions of "Treating the Sick" and "Disease"

Section 147.01 (1), Wisconsin Statutes, 1941, defines what constitutes treating the sick in Wisconsin:

(a) "To treat the sick" is to examine into the fact, condition, or cause of human health or disease, or to treat, operate, prescribe, or advise for the same, or to undertake, offer, advertise, announce, or hold out in any manner to do any of said acts, for compensation, direct or indirect, or in the expectation thereof.

(b) "Disease" includes any pain, injury, deformity, or physical or mental illness or departure from complete health and proper condition of the human body or any of its parts.

Even such minor departures from complete health, as astigmatism, headaches and partial paralysis, constitute "disease" within the meaning of the Basic Science Law, and advising as to their care constitutes "treating the sick."[14] The use of roentgenography for diagnosis and treatment is treatment of the sick.[15] The use of natural forces, such as light, heat, air, water and exercise, in the treatment of disease, constitutes treating the sick within the provisions of the Basic Science Law.[16] Diagnosis and treatment of unhealthy conditions of the skin and scalp constitute treating the sick.[17]

Board of Examiners in the Basic Sciences

The State Board of Examiners in the Basic Sciences consists of three lay educators appointed by the Governor to serve for a term of six years each.[18] None of the appointees may be on the faculty of any department teaching methods of treating the sick.[19]

The board keeps a complete record of all applications, examinations, registrations, fees, decisions, orders and proceedings. It is authorized to appoint, subject to the civil service law, such competent and recognized experts as shall be necessary in examinations, as well as clerks. Their compensation, together with the compensation of board members, may not exceed in amount the fees received.[20]

Application for Registration

Application for a certificate of registration must be made to the Board of Examiners in the Basic Sciences. Such application must be accompanied by satisfactory evidence of good moral character and preliminary education equivalent to graduation from an accredited high school of this state, together with a fee of $10.[21] *The applicant is not required to disclose the professional school he attended or the system of treating the sick which he intends to pursue.*[22]

The preliminary high school requirement is waived only as to those applicants who were attending a professional school which was teaching the basic sciences on February 1, 1925.[23]

Basic Science Examination and Certificate

The examinations are conducted at least four times a year at times and places fixed by the board, and are both written and practical.[24] The applicant is examined in anatomy, physiology, pathology and diagnosis,[25] and if he achieves the grade of 75 per cent in each subject, he receives a certificate in the basic sciences signed by the president and secretary of the board. In the event the applicant fails in one subject only, he may be reexamined in that subject at any examination within one year without further fees, but if he fails in two or more, he must await the passage of one year, and must reapply and be reexamined in all subjects.[26]

An applicant seeking one of the limited licenses, such as for chiropody, need only state to the board that his practice is to be confined to one organ or set of organs, and his examination and certificate are limited accordingly.[27]

Since a certificate in the basic sciences does not authorize one to engage in the practice of treating the sick, compliance with the law is merely a condition precedent to taking the examination of one of the licensing boards. The Basic Science Law in no manner supplants conditions imposed by the various licensing boards.[28]

Reciprocity

The board may issue a certificate to an applicant who presents satisfactory evidence of having passed examination in the basic sciences before a legal examining board or officer of another state, or of a foreign country, if the standards are as high as those of this state, and upon the payment of a fee of $15.[29] This does not authorize the board, however, to accept the results of an examination conducted by the National Board of Medical Examiners in lieu of its own examination, for the reason that the National Board of Medical Examiners is a voluntary board as distinguished from a board created by law.[30]

Court Review

The action of the board in granting or denying a certificate is subject to review by appeal in the manner provided in Chapter 227, Wisconsin Statutes. The applicant affected, or any state examining board for any branch of treating the sick, may take such appeal.

The court may then dismiss the action, or remand the record to the board for further examination or investigation, or for modification or reversal of its

action. In these actions the Attorney General appears for the board, and no costs are taxed by either party.[31] No such action has ever been instituted since organization of the board in 1925.

Revocation

A certificate of registration in the basic sciences is subject to revocation for the causes and in the manner provided in Section 147.20, Wisconsin Statutes.[32] For discussion of that section and procedure under it see "Revocation or Suspension of License," page 56.

LICENSING REQUIREMENTS AND PROCEDURES

General

Under the provisions of the statutes, treating the sick is governed in the following terms:

147.14. Practice. (1) No person shall practice or attempt or hold himself out as authorized to practice medicine, surgery, or osteopathy, or any other system of treating bodily or mental ailments or injuries of human beings, without a license or certificate of registration from the state board of medical examiners, except as otherwise specifically provided by statute, nor unless he shall record the same with the county clerk of the county in which he resides and pay a fee of fifty cents for such recording. Nonresidents shall file such license or certificate in each county in which they shall practice. The clerk shall enter in a book kept for that purpose the date of the license or certificate, the name of the licensee, school or practice shown, and the date of the recording.

Several exceptions to this provision are created by virtue of a statutory provision that exempts those engaged in healing the sick through Christian Science or by mental or spiritual means;[33] while still another provision exempts from licensure requirements those engaged as commissioned officers of the Army, Navy, or federal public health service, or licensed practitioners in medicine and surgery or osteopathy and surgery of other states or countries who may be in actual consultation with resident licensed practitioners of this state. Nor does this law apply to gratuitous prescribing and administering of family remedies, or to treatment rendered in an emergency.[34]

Still others are exempt from the provisions of this section by reason of their compliance with other specific licensing statutes, such as those dealing with chiropractic and optometry.

However, there is no "No Man's Land" in licensure in Wisconsin. Specific theories or systems of treating the sick not recognized in Wisconsin *may not be pursued as a vocation.* This includes such cultists as naturopaths, naprapaths, and others. To treat the sick in Wisconsin, one must be licensed specifically to exercise that privilege under the Wisconsin licensure law.[35]

Each specific licensing field in Wisconsin is grouped under one of the several licensing boards. The State Board of Medical Examiners licenses applicants for the practice of medicine and surgery, osteopathy and surgery, midwifery, massage and hydrotherapy, and chiropody. Section 147.16 of the statutes states that all applicants in these several fields of treating the sick are to be given the same examination, so far as practicable, in the fields of anatomy, physiology, general diagnosis, pathology, histology, chemistry, hygiene and sanitation.

There are also licensing boards in chiropractic and optometry, dentistry and nursing. The latter two of these boards will not be discussed in this article, because each embraces a well defined and well regulated professional field, which does not call for extended comment here.

Licensure requirements and procedure, together with the powers of the respective licensing boards, will be treated in the pages following. As a matter of convenience for the reader, the licensing requirements and procedure for the several types of applicants will be summarized under the particular system of treating the sick, rather than by a classification of licensing boards.

Registration

Commencing in 1944 every person licensed to and engaged in or entering upon the practice of medicine and surgery or osteopathy or osteopathy and surgery shall in January of each year register with the Secretary of the Wisconsin State Board of Medical Examiners and shall notify the State Board of Examiners within thirty days of any change of residence or professional address. The fee shall not exceed $3 per year. Each person registering shall receive a printed list of the entire registration. No registration shall be permitted of any one who has been found guilty of any unprofessional act described in Section 147.20 and upon conviction of any of said acts, the registration of such person shall be annulled, subject to his right of appeal. The registry provision shall not apply to physicians serving in the armed forces of the United States or of an allied government. Chap. 155, Laws of 1943.

Medicine and Surgery

Examining Board.—The examining body for applicants for license to practice medicine and surgery is the State Board of Medical Examiners, which is composed of eight licentiates, appointed by the governor for four-year terms.[36] No instructor, stockholder, member of, or persons financially interested in any school having a medical or osteopathic department, is eligible.[37] The board meets regularly on the second Tuesday of January at Madison, and on the last Tuesday of June at Milwaukee, and at such other times as are considered advisable. At the annual June meeting a president and secretary-

treasurer are elected. It is the duty of the secretary-treasurer to receive for the board all money, and to pay it into the state treasury,[38] as well as to keep a record of its proceedings and a register of applications, licenses and certificates of registration issued.[39]

There is appropriated from the state general fund to the board for the execution of all its functions, all money received by it and paid into the general fund.[40] Of this there is allotted to each examiner not more than $10 for each day actually spent, together with actual and necessary expenses, to the board members.[41]

All applications for licensure from the State Board of Medical Examiners must be made to the board at the time and place designated by it, or at any regular meeting.[42]

Educational Requirements.—The applicant must have the three-year premedical course of the University of Wisconsin or its equivalent. Educational requirements of applicants for license to practice medicine and surgery are summarized in Table 1, column 1, page 62.

Each applicant must also file with the board a verified statement that he is familiar with the state health laws and with the rules and regulations of the State Board of Health relating to communicable diseases,[43] satisfactory evidence of good moral and professional character[44] and proof of the fact that he is twenty-one years of age.[45] An applicant for license to practice medicine and surgery must also present a diploma from a reputable professional college approved and recognized by the board.[46]

The State Board of Medical Examiners has broad discretion in determining the reputability of professional schools,[47] and where it is impossible for the board to determine whether the college is reputable, the burden is upon the applicant to prove its reputability.[48]

In the event the applicant feels that the board was unjust in its determination that the professional school from which he was graduated did not meet its requirements, he may mandamus the board to grant him a license.[49]

Under no conditions or circumstances may the board issue a temporary license or certificate to an applicant in any system of treating the sick.

Examination and Licensure.—The State Board of Medical Examiners examines all applicants in anatomy, physiology, general diagnosis, pathology, histology, chemistry, hygiene and sanitation after first satisfying itself that all educational requirements have been met.[50] The board, by rule, may accept a basic science certificate in lieu of any examination in the fields of anatomy, physiology, pathology and diagnosis.[51] In addition to the uniform examination in the above subjects, the applicant is also examined by the board in such further subjects as are usually taught in a reputable medical school.[52] The board, if six of its members find the applicant qualified, then issues a license to practice medicine and surgery, signed by the president and secretary, and attested by the seal of the board.[53]

This license must be recorded by the physician with the county clerk of the county in which he resides, the recording fee being 50 cents. Nonresidents shall file such licenses in each county in which they practice. Until such license has been issued and recorded, no person may practice or attempt or hold himself out as authorized to practice medicine and surgery.[54] No person who is unlicensed, or who has not recorded his license as above provided, has the right to collect by law any compensation for professional services or to testify in a professional capacity, except in criminal actions, or under certain conditions, except for nonresident expert witnesses in medicine and surgery, or osteopathy and surgery.[55]

Licensure without Examination.—The board may license without examination a person holding a license to practice medicine and surgery in another state, if in such state the requirements imposed are equivalent to those of this state, upon presentation of the license and a diploma from a reputable professional college approved and recognized by the board, or an honorably discharged surgeon of the Army or Navy, or of the federal public health service, upon filing of a sworn and authenticated copy of his discharge. The fee for license without examination shall be fixed by the board at not less than the reciprocity fee in the state whose license the applicant presents, but shall in no case be less than $50. A license from another state confers no privilege to practice in this state beyond the right to obtain a license by reciprocity in accordance with the statutes.[56]

Itinerants.—The following statute specifically governs licensure of the itinerant practitioner to practice any form or system of treating the afflicted:

147.18 Itinerants. Itinerant practitioners of medicine, surgery or osteopathy or of any form or system of treating the afflicted shall obtain an annual license in addition to the regular license or certificate of registration, and shall pay therefor two hundred fifty dollars per annum. Persons practicing medicine, surgery or osteopathy or professing or attempting to treat or heal ailments or injuries of the human body who go from place to place at regular or irregular intervals less frequently than once a week, are itinerant practitioners.

Revocation or Suspension of License.—Three procedures have been established by statute for the revocation or suspension of a license or certificate issued by the Wisconsin State Board of Medical Examiners:

(a) By civil action

The district attorney is authorized to bring civil action in circuit court against the holder of a license to practice medicine and surgery and in the name of the state to revoke or suspend his license upon a verified complaint received by him charging the holder of the license with having been guilty of

immoral or unprofessional conduct, or with having obtained a license by fraud, perjury or error.[57] The same subsection sets out certain other procedural features of such a suit.

The words "immoral or unprofessional conduct" are defined by section 147.20 (1), as follows:

(a) Procuring, aiding or abetting a criminal abortion; (b) advertising in any manner either in his own name or under the name of another person or concern, actual or pretended, in any newspaper, pamphlet, circular, or other written or printed paper or document the curing of venereal diseases, the restoration of "lost manhood," the treatment and curing of private diseases peculiar to men or women, or the advertising or holding himself out to the public in any manner as a specialist in diseases of the sexual organs, or diseases caused by sexual weakness, self-abuse or excessive indulgences, or in any diseases of a like nature or produced by a like cause, or the advertising of any medicine or any means whatever whereby the monthly periods of women can be regulated or the menses re-established, if suppressed, or being employed by or in the service of any person, or concern, actual or pretended so advertising; (c) the obtaining of any fee, or offering to accept a fee on the assurance or promise that a manifestly incurable disease can be or will be permanently cured; (d) wilfully betraying a professional secret; (e) indulging in the drug habit; (f) conviction of an offense involving moral turpitude.

The license of a physician who attempts to perform an abortion may be revoked or suspended, and the fact that he was acquitted of the same charge in a criminal action does not bar a proceeding under this section.[58] Nor is the time within which to bring such action, after the offense has been committed, important.[59] The attorney general has further ruled that a physician who directed a patient to an abortionist who did, in fact, perform an abortion, is guilty, as an accessory before the fact, and his license is subject to revocation or suspension under this section.[60]

Subject to the limitation that any act in question must occur in the course of professional conduct, defrauding through use of the mails has been ruled to be a crime involving moral turpitude under section 147.20, while violation of the Federal Narcotic Act probably is not; indulgence in a drug habit is immoral or unprofessional conduct under section 147.20.[61]

(b) By action of the board

The statute also provides that when any person licensed by the State Board of Medical Examiners is convicted of a crime committed in the course of his professional conduct, the clerk of the court shall file with the board a certified copy of the information and of the verdict and judgment; and upon such filing the board shall revoke or suspend the license or certificate.[62]

The license of a physician who has been convicted of a crime cannot be revoked or suspended by the board unless the crime was committed in the course of his professional conduct. If the crime of which the person is convicted, however, involves moral turpitude, the license may be revoked or suspended by a circuit court action described in part (a) of this section.[63]

Revocation or suspension of a license under this section requires affirmative action by the board, and the right to practice continues until such action is taken.[64] There is no time limitation within which the board must act.[65]

The board has no authority to restore a revoked or suspended license.[66] It may be restored only after a first revocation, and then only by subsequent order of the trial court upon notice to the district attorney who prosecuted, or in the event of his disability, his successor in office, and upon written recommendation of the president of the State Board of Medical Examiners with a finding by the court that the applicant is of good moral and professional character and that justice demands the restoration.[67]

(c) State Medical Grievance Committee

In 1935 there was enacted the section quoted below.[68] It was designed to provide a body of qualified public officers to investigate, hear, and act upon practices by persons licensed to practice medicine and surgery which are inimical to the public health.

The statute follows:

The state health officer, the secretary of the state board of medical examiners, and the attorney-general or deputy attorney-general are hereby constituted ex officio a state medical grievance committee, to investigate, hear, and act upon practices by persons licensed to practice medicine and surgery under section 147.17, that are inimical to the public health. The state health officer shall be chairman of the committee. Meetings of the committee shall be held at the call of the chairman. Any member thereof shall have power to subpoena and swear witnesses, and take evidence. The committee shall have power to warn and to reprimand, when they find such practice, and to institute criminal action or action to revoke license when they find also probable cause therefor under criminal or revocation statute, and the attorney-general may aid the district attorney in the prosecution thereof. The records of said committee shall be kept by and be in the custody of the chairman thereof. No member of said committee shall receive any extra compensation therefor, nor other than his actual expenditures in attending upon his duties thereon.

Osteopathy and Surgery

Examining Board.—The examining board for applicants for a license to practice osteopathy and surgery is the State Board of Medical Examiners, as in the case of applicants for license to practice medicine and surgery (See also page 55).[69]

Educational Requirements.—These requirements are summarized in Table 1, column 2, page 62. Special attention is called to the 1941 amendment providing, in substance, that after June, 1948, an applicant must have had two years of college training, including physics, chemistry, biology and English, in an institution accredited by the University of Wisconsin.[70]

Examination and Licensure.—The board examines applicants for license to practice osteopathy and surgery in anatomy, physiology, general diagnosis, pathology, histology, chemistry, hygiene and sanitation, but by rule is also permitted to accept a basic science certificate in lieu of examination in anatomy, physiology, pathology and diagnosis.[71] An applicant must be twenty-one years of age, and must also file a verified statement that he is familiar with the state health laws and the rules and regulations of the State Board of Health relating to communicable diseases.[72]

In addition to the uniform examination in the above subjects, the State Board of Medical Examiners is further required to examine applicants in branches usually taught in a reputable osteopathic college.[73] It should be noted that the examination does not include materia medica, since applicants in the field of osteopathy and surgery are not trained in this field, as are graduates of medical colleges. If six members of the board find the applicant qualified, it then issues a license to practice osteopathy and surgery, signed by the president and secretary, and attested by the seal of the board.[74]

The license, as in the case of a physician and surgeon, must be recorded with the county clerk of the county in which the licensee resides, and a fee of 50 cents paid for such recording. Nonresidents must file such license in each county in which they practice.[75]

Reciprocity.—The statutory provision relating to reciprocity where osteopaths are concerned is the same as that applicable in the case of physicians and surgeons. See "Licensure Without Examination," page 56.

Itinerants.—The statutory provision appearing under the title "Itinerants," page 56, also has equal application to osteopaths.

Revocation or Suspension.—The same statutory authority, and in general the same case authority and attorney general's opinions having to do with licenses to practice medicine and surgery, have equal application to licenses to practice osteopathy and surgery. See "Revocation or Suspension of License," page 56.

Chiropody

Examining Board.—The State Board of Medical Examiners, as earlier noted, likewise is the examining board for applicants to practice chiropody. See page 55, where the composition of the board is discussed.

Educational Requirements.—Educational requirements for applicants to practice chiropody are outlined in Table 1, column 3, page 62.

Examination and Certificate.—The statutes provide that the State Board of Medical Examiners shall select three registered chiropodists to conduct the examination under its supervision, one of whom is to be appointed as president, and another as secretary, of the chiropody examiners, all three to receive the same compensation as members of the board.

The examination is required to be both scientific and practical, to be written in English, and to cover anatomy and physiology of the feet, diagnosis of the foot ailments and deformities which the chiropodist is authorized to treat, materia medica, chiropodial orthopedics, bacteriology, pathology, histology, therapeutic chemistry, and minor surgery and bandaging pertaining to ailments of the feet, not including any amputation, and the mechanical treatment of congenital or acquired deformities of the feet. The written examination may be supplemented by oral and clinical examination.[76]

If the State Board of Medical Examiners finds the applicant qualified, it shall issue a certificate of registration which is required to be renewed on February 1 of each year upon application and the forwarding of a $2 annual renewal fee to the secretary of the chiropody examiners on or before January 31. Upon receipt of such application, the chiropody examiners are required to send the application fee to the State Board of Medical Examiners for renewal, and the statute levies a renewal fee of $7 against any chiropodist who fails to renew his application on or before January 31 of any year.[77]

The certificate shall be recorded with the county clerk of any county in which the holder practices.[78]

The Wisconsin statutes contain no reciprocity provision for applicants for a certificate to practice chiropody.

Itinerants.—The statutory provisions appearing under the title "Itinerants," page 56, have equal application to itinerant chiropodists.

Revocation of Certificate.—The statute provides that the certificate of registration may be revoked in the manner and for any of the causes set out in section 147.20 which is discussed on page 57. Among additional reasons for revocation of certificate is the failure to reregister before July 1 of any year or for "unprofessional conduct," which term includes the unemployment of solicitors to obtain business, obtaining fees by fraud or deceit, wilfully betraying professional secrets, and the like.[79] The penalties for violation of Chapter 154 relating to chiropody are set out in another section and include fine on the first offense and fine and imprisonment, or both, on a subsequent offense for persons convicted of fraud in connection with a chiropodist degree, practicing under a false or assumed name and similar offense.[80].

Midwifery

Examining Board.—The examining board for applicants to practice midwifery is the State Board of Medical Examiners, and for general information on this body, its composition and general powers, see page 55.

Educational Requirements.—Educational requirements of applicants are summarized in Table 1, column 4, page 62.

Examination and Certificate.—The applicant is required to take a written examination in the anatomy of the female pelvis, anatomy and physiology of the organs contained in the female pelvis, symptoms, diagnosis, physiology and complications of pregnancy, diagnosis, course and management of labor, and care of mother and child for the first ten days.[81]

The examination is required to be prepared and conducted by three members of the State Board of Medical Examiners appointed by the president, and if six members of the board find the applicant qualified it shall grant a certificate of registration, signed by the president and secretary of the board and attested by its seal.[82] The certificate should be recorded by the register of deeds of the county in which the midwife resides or practices, except that in Milwaukee she shall record the certificate with the registrar of vital statistics and pay 50 cents for such recording.[83]

The statutes contain no provision with reference to or the licensing of midwives by reciprocity.

Itinerants.—The general statute appearing under the title "Itinerants." page 56, has equal application to itinerant midwives.

Revocation or Suspension of Certificate.—By statute, the provisions of section 147.20 which relate to revocation or suspension of license of physicians and osteopaths apply to midwives, except for the definition of "immoral or unprofessional conduct." This latter provision is defined by statute to mean in the case of midwives:

(a) procuring, aiding or abetting a criminal abortion; (b) advertising in her own or any other name in a written or printed paper or document in an obscene manner derogatory to good morals, or advertising means whereby the menses can be regulated, suppressed or reestablished or being in the service of anyone so advertising; (c) indulging in the drug habit; (d) conviction of an offense involving moral turpitude.[84]

Massage and Hydrotherapy

Examining Board.—The examining board for applicants to practice massage and hydrotherapy is the State Board of Medical Examiners.[85] For general information as to the composition and powers of this body, see "Examining Board," page 55.

Educational Requirements.—For educational requirements of applicants to practice massage and hydrotherapy, see Table 1, column 5, page 62. In spite of the positive statutory requirement that all persons treating the sick, unless expressly exempt, shall possess a basic science certificate in addition to passing successfully an examination given by the State Board of Medical Examiners in anatomy, physiology, general diagnosis, pathology, histology, chemistry, hygiene and sanitation, the Attorney General of Wisconsin has ruled that a basic science certificate is not a prerequisite to a certificate to practice massage and hydrotherapy, and that opinion has been followed in practice.[86]

The applicant also files a verified statement that he is familiar with the state health laws and rules and regulations of the State Board of Health relating to communicable diseases.[87]

Examination and Certificate.—The statute requires that the applicant be examined by the board in physiology, descriptive anatomy, pathology and hygiene, and that he be further examined in massage and hydrotherapy, under the supervision of the board by a registered practitioner selected by the board and receiving the same compensation as the board members.

If a majority of the board members find the applicant qualified, it shall issue a certificate of registration to practice massage and hydrotherapy signed by the president and secretary and attested by its seal, which certificate shall authorize practice in massage, hydrotherapy, and educational gymnastics, *but not the treatment of a specific disease except upon the advice of a licensed medical physician,* the latter being qualified to practice massage and hydrotherapy by virtue of his license without holding a certificate for the practice of massage and hydrotherapy.[88] The certificate should be recorded by the holder with the county clerk of the county in which he resides and a fee of 50 cents paid for such recording.[89] There is no provision in the statutes for licensing by reciprocity for the practice of massage and hydrotherapy.

Itinerants.—The general statute under the title "Itinerants," page 56, has equal application to itinerant practitioners of massage and hydrotherapy.

Revocation or Suspension of Certificate.—The statutory provisions discussed under the title "Revocation or Suspension of License," page 56, have general application to holders of certificates of registration in the field of massage and hydrotherapy.[91]

Chiropractic

Examining Board.—The examining body for applicants to practice chiropractic shall be the State Board of Examiners in Chiropractic, comprised of

three chiropractors appointed by the Governor with the advice and consent of the Senate, who must have been continuous residents and practitioners of chiropractic in the state for the preceding three years, none of whom is an officer or employer, nor financially interested in any school or college of chiropractic, and none of whom is a graduate of any school teaching a method of treating the sick other than chiropractic. The term of office is six years, and a vacancy shall be filled for the unexpired term. Within thirty days after appointment, the board will meet for the election of a chairman and secretary. Members are compensated at the rate of $10 a day for each day actually spent, and for the actual and necessary expenses incurred in the performance of their official duties.

The board conducts examinations at least twice a year at such times and places as it determines.[92]

Educational Requirements.—Educational requirements for applicants for license to practice chiropractic are summarized in Table 1, column 6, page 62.

Examination and Licensure.—Applicants for license to practice chiropractic must first present a basic science certificate, and are then examined by the State Board of Examiners in Chiropractic, in subjects usually taught in reputable schools of chiropractic.[93] The statute also provides that all licenses issued by the board shall expire on the thirty-first of December following their issuance, except that any holder of a license may have the same renewed from year to year by payment of an annual fee of $5. Satisfactory evidence must be presented to the board that the holder of the license in the year preceding the application for renewal, has attended at least one of the two-day educational programs conducted, supervised and directed by the Wisconsin Chiropractic Association. Exemption from this latter requirement is granted only upon a showing satisfactory to the board that attendance at such educational program was unavoidably prevented. This annual education requirement has been ruled by the attorney general of Wisconsin to be constitutional.[94]

The license granted a chiropractor and his basic science certificate must be recorded with the county clerk of any county in which he shall practice or attempt or hold out to practice, and a fee of 50 cents paid for each recording.[95]

The statutes contain no provision with reference to reciprocal licensing.

Itinerants.—The general statute dealing with physicians under the title "Itinerants," page 56, has equal application to itinerant chiropractors.

Revocation or Suspension of License.—The statutes provide that licenses to practice chiropractic shall be subject to revocation or suspension for the causes and in the manner provided in section 147.20.[96] This section refers to revocation or suspension of licenses and certificates issued by the State Board of Medical Examiners, and is discussed under "Revocation or Suspension of License," page 56.

Optometry

Examining Board.—The examining board for applicants for certificate of registration to practice optometry is the Wisconsin Board of Examiners in Optometry. It consists of five members appointed by the Governor for terms of five years each, each of such appointees to have been a resident of the state, actively engaged in the practice of optometry for at least five years immediately preceding appointment. The board chooses annually from among its members, a president and secretary, each of whom is empowered to administer oaths and take affidavits and to certify thereto under the seal of the board. The board meets at least once every six months at the State Capital, and on January 1 of each year reports its proceedings to the Governor, including an account of monies received and disbursed. The president and secretary also file annually with the Governor a verified list of optometrists qualified to serve as members of the board.[97]

Educational Requirements.—The educational requirements for applicants are summarized in Table 1, column 7, page 62. The supreme court has recognized optometry as a mechanical art requiring skill and knowledge, but not as a profession, although the fact remains that the conditions to which optometrists apply their skill constitutes "treating the sick" within the meaning of the basic science law.[98] That such was the conclusion of the optometrists themselves follows from the fact that they secured the introduction and supported a specific amendment to secure exemption from the effect of that law.[99]

Examination and Certificate.—The examination, which is not required of licensed physicians and surgeons, is by statute "confined to such knowledge as is essential to the practice of optometry" and includes anatomy, physiology, pathology of the eye and its appendages, normal and abnormal refractive, accommodative and muscular conditions and coordinations of the eye, and subjective and objective optometry including the fitting of glasses, the principles of lens construction and frame adjusting, and such other subjects as the board deems necessary. An applicant who fails at an examination has the privilege of taking another examination upon payment of a $10 fee at any future regular meeting of the board.[100] The board issues a certificate of registration to a successful applicant,[101] which is renewed on or before the first of January of each year on payment of a reregistration fee of $2.[102] Everyone practicing optometry is to display in a conspicuous place at the entrance of his place of business the name of each person so practicing therein.[103]

The holder of a certificate shall present the same or a certified copy to the county clerk of the county of his residence with a fee of 50 cents, and if he moves his residence to, or desires to practice in, another county he shall file a certified copy of the county clerk's record or a new certificate with the county clerk of such county with a fee of 50 cents for each recording before he practices in such other county. The board's fee for reissuance of a certificate is $1, and the county clerk's fee for certifying a record is the same amount. A certificate or certified record not recorded within six months after issuance is void.[104]

Reciprocity.—One who has been admitted to practice optometry in another state may be issued a certificate at the discretion of the board upon payment of $25 and production of a certificate showing that he has passed an examination in such other state and has actually practiced there for two years.[105]

Itinerant Optometrists.—The general statute under the title "Itinerants," page 56, has equal application to itinerant optometrists.

Revocation or Suspension of Certificate.—The State Board of Examiners in Optometry may revoke or suspend a certificate if the holder fails to pay the annual reregistration fee upon thirty days' notice of such proposed revocation or suspension. The board may revoke or suspend a certificate obtained through error or fraud, or where the recipient is grossly incompetent, guilty of immoral or unprofessional conduct, or has obtained or sought to obtain anything of value by fraudulent representation in the practice of optometry. The statutes also set out the procedure to be followed by the board in preferring charges against the holder of a certificate of registration, together with the procedure on appeal to the circuit court.[106]

One whose certificate has been revoked or suspended may have it regranted to him, after one year, upon application and satisfactory proof that the cause of revocation or suspension no longer exists.[107] "Unprofessional conduct," as that phrase is used in connection with revocation or suspension of a certificate of registration, is specifically defined by statute, and should be carefully read by interested persons. It includes any conduct of a character likely to deceive or defraud the public; price advertising on lenses or complete glasses; advertising free examinations; untruthful or misleading advertising; splitting or dividing with any person any fee for optometric services; and similar acts.[108]

A later section also holds guilty of unprofessional conduct any optometrist in the employ of a person who violates any of the provisions of chapter 153, Wisconsin Statutes, relating to optometry, who, being given thirty days' notice by the board of such violation, continues in the employ of the violator.[109]

Prohibited Advertising

It is unlawful to advertise directly or indirectly in definite or indefinite price of credit terms on lenses, frames, complete glasses or any optometric services; to advertise in a manner that will tend to mislead or deceive the public; to solicit patronage by advertising that he or some other person or group possesses superior qualifications or are best trained to perform the service; or to render any optometric services pursuant to such advertising. Chap. 273, Laws of 1943.

Nurses—Reciprocity

The holder of a certificate of nursing of another state shall be granted a certificate without examination in Wisconsin if her credentials and educational qualifications are equivalent to those required in Wisconsin. The Committee on Nursing Education shall decide the question of equivalency. Chap. 480, Laws of 1943.

Licensed Attendants

Examining Board—The Board of Examiners for nurses is the Examining Board for applicants to be "Licensed Attendant."

Educational Requirements—Applicant must be at least 19 years of age with a high school education or its equivalent and must have completed the work prescribed by an accredited school for attendants, which shall be connected with a reputable hospital having a daily average census of at least 40 patients and having facilities for surgical, medical and obstetric cases. The school must offer a course of at least nine months, but not to exceed twelve months.

Examination and Certificate—Applicant is required to take a written examination prepared by the Board of Examiners for nurses and subject to approval of the Committee on Nursing Education. Examinations shall be held twice a year at places publicly designated by the State Board of Health and applicant must pay a $5 fee.

Successful applicants will receive a license as "Licensed Attendant" and may append the letters "L.A." after her name.

Revocation—The license may be revoked by the Committee on Nursing Education pursuant to Section 149.07 of the Wisconsin Statutes.

Reciprocity—The law provides for reciprocity with other states which have substantially the same standards. Chap. 304, Laws of 1943.

Citations

Note: All references below, beginning with the abbreviation "Sec." are from the designated chapters and sections of the 1941 Wisconsin statutes. References containing the abbreviation "Wis." are from the designated volume and page of decisions of the supreme court of Wisconsin. References containing

TABLE 1.—*Wisconsin Educational and Other Requirements Preliminary to Examination for License to Treat the Sick (Excluding Dentistry and Nursing)*

Applicant for License in	Preliminary	Undergraduate	Professional and Personal	Additional Requirements	Application Fee
1. Medicine and surgery (Secs. 147.15; 147.17 (1))	Equivalent to graduation from an accredited high school of this state.	Equivalent of 3-year premedical course at University of Wisconsin, including physics, chemistry, biology and either German or French.	Diploma from reputable professional college; good moral and professional character; applicant to be 21 years of age. (No foreign schools, except Canadian, are approved)	If not required by the professional school for graduation, internship of at least 12 months in a reputable hospital.	$20 with an additional $5 if license is issued.
2. Osteopathy and surgery (Secs. 147.15;147.17(1))	Equivalent to graduation from an accredited high school of this state.	After June, 1948, 2 years' college work including physics, chemistry, biology and English in an institution accredited by University of Wisconsin.	Diploma from reputable professional college; good moral and professional character; applicant to be 21 years of age. (No foreign schools, except Canadian, are approved)	None	$20 with an additional $5 if license is issued.
3. Chiropody (Sec. 154.02)	Equivalent to graduation from an accredited high school.	One year in a recognized college of liberal arts or science, since July 1, 1940.	Completion in a reputable school of chiropody, a course at least equivalent to 3 years of 37 weeks of 30 class hours each, in anatomy and physiology of the feet, and diagnosis of foot ailments and deformities which the chiropodist is authorized to treat, materia medica, chiropodial orthopedics, bacteriology, pathology, histology, therapeutic chemistry, minor surgery and bandaging pertaining to ailments of the feet and the mechanical treatment of congenital or acquired deformities of the feet. Applicant must be of good moral and professional character and more than 21 years of age.	None	$20
4. Midwifery (Sec. 150.02)	None	None	Diploma from a reputable school of midwifery which is a school connected with a reputable hospital or sanatorium giving at least a 12 months' course in the science and practice of midwifery and practical experience in at least 20 cases; good moral and professional character.	None	$10 with an additional $5 if certificate is issued.
5. Massage and hydrotherapy (Sec. 147.185)	Equivalent to graduation from an accredited high school of this state.	None	Completion, in a scientific or professional school, of an adequate course in physiology, descriptive anatomy, pathology, and hygiene; good moral and professional character.	None	$20 with an additional $5 if certificate is issued.
6. Chiropractic (Sec. 147.23(3))	Equivalent to graduation from an accredited high school of this state.	None	Diploma from a reputable school of chiropractic, having a residence course of not less than 3 years, consisting of not less than 4,000 30-minute class hours; good moral character.	None	$25
7. Optometry (Secs. 153.03; 153.04)	High school education or its equivalent as determined by the board.	None	Attendance at an optometry school for at least 2 years; not less than 4,000 hours actual instruction; or after attending optometry school for 1 year shall have served as assistant to a registered optometrist for at least 2 years, providing he has registered with the board when not less than 19 years of age, as an assistant for at least 2 years. Applicant must be 21 years of age to write examination.	None	$25 for application, plus $10 for examination.

the abbreviations "Atty. Gen." are from the designated volume and pages of the official opinions of the attorney general of Wisconsin.

[1] Sec. 147.01 (1), (c).
[2] Sec. 147.02; 147.14 (1).
[3] Sec. 147.14 (1).
[4] Sec. 147.04.
[5] Sec. 147.02; Sec. 147.19 (1).
[6] Sec. 147.02.
[7] Sec. 147.01 (2).
[8] Ibid.
[9] Sec. 147.02; Sec. 147.19 (2).
[10] Sec. 147.02; Sec. 147.19 (1).
[11] Sec. 147.02; Sec. 147.19 (1).
[12] 26 Atty. Gen. 591, (1937).
[13] Sec. 147.09; 23 Atty. Gen. 87.
[14] Nickell v. State, 205 Wis. 614.
[15] 16 Atty. Gen. 560.
[16] 20 Atty. Gen. 107.
[17] 21 Atty. Gen. 1135.
[18] Sec. 147.03.
[19] Ibid.
[20] Sec. 147.12.
[21] Sec. 147.05.
[22] Sec. 147.06.
[23] Sec. 147.05; 22 Atty. Gen. 297.
[24] Sec. 147.06.
[25] Ibid.; Sec. 147.01 (1), (c).
[26] Sec. 147.07.
[27] Ibid.
[28] 26 Atty. Gen. 110.
[29] Sec. 147.08.
[30] 23 Atty. Gen. 303.
[31] Sec. 147.11.
[32] Sec. 147.10.
[33] Sec. 147.19 (2).
[34] Sec. 147.19 (1).
[35] Sec. 147.14 (1).

[36] Sec. 147.13 (1).
[37] Ibid.
[38] Sec. 147.13 (2).
[39] Sec. 147.13 (5).
[40] Sec. 20.44 (1).
[41] Sec. 147.13 (3); Sec. 20.44 (1), (a).
[42] Sec. 147.15.
[43] Ibid.
[44] Ibid.; State ex rel. Dubin v. State Board of Med. Exam., 222 Wis. 227, 223.
[45] Sec. 147.17 (1).
[46] Sec. 147.15.
[47] 19 Atty. Gen. 537; 25 Atty. Gen. 459.
[48] 25 Atty. Gen. 459; 26 Atty. Gen. 420.
[49] State ex rel. Blank v. Gramling, 219 Wis. 196, 204.
[50] Sec. 147.16.
[51] Sec. 147.04.
[52] Sec. 147.16.
[53] Sec. 147.17 (1).
[54] Sec. 147.14 (1).
[55] Sec. 147.14 (2).
[56] Sec. 147.17 (1); 28 Atty. Gen. 685, 686.
[57] Sec. 147.20 (2).
[58] 12 Atty. Gen. 144; State v. Lewis, 164 Wis. 363.
[59] State v. Schaeffer, 129 Wis. 459, 467.
[60] 24 Atty. Gen. 108.
[61] 18 Atty. Gen. 289; 21 Atty. Gen. 476.
[62] Sec. 147.20 (3).
[63] 18 Atty. Gen. 289.
[64] 26 Atty. Gen. 378.
[65] 30 Atty. Gen. 43.
[66] 2 Atty. Gen. 571.
[67] Sec. 147.20 (4); 22 Atty. Gen. 942.
[68] Sec. 147.195.
[69] Sec. 147.14 (1).
[70] Sec. 147.15.
[71] Sec. 147.16; Sec. 147.04.
[72] Sec. 147.17 (1); 147.15.
[73] Sec. 147.16.
[74] Sec. 147.17 (1).
[75] Sec. 147.14 (1).
[76] Sec. 154.03.
[77] Sec. 154.04.
[78] Ibid.
[79] Sec. 154.05.
[80] Sec. 154.06.
[81] Sec. 150.03.
[82] Ibid.; Sec. 150.04 (1).
[83] Sec. 150.04 (2).
[84] Sec. 150.05 (2).
[85] Sec. 147.185.
[86] Sec. 147.02; Sec. 147.04; Sec. 147.16; 26 Atty. Gen. 591.
[87] Sec. 147.185.
[88] Sec. 147.185; 28 Atty. Gen. 685, 686.
[89] Sec. 147.14 (1).
[90] Sec. 147.185.
[91] Sec. 147.20.
[92] Sec. 147.23 (2); Sec. 147.23 (4).
[93] Sec. 147.23 (4).
[94] Sec. 147.23 (7); 24 Atty. Gen. 647.
[95] Sec. 147.23 (1).
[96] Sec. 147.23 (6).
[97] Sec. 153.02.
[98] State ex rel. Harris v. Kindy Optical Co. 235 Wis. 498, 501.
[99] Sec. 147.01 (2).
[100] Sec. 153.04.
[101] Sec. 153.05 (1).
[102] Sec. 153.05 (3).
[103] Sec. 153.05 (5).
[104] Sec. 153.05 (4).
[105] Sec. 153.05 (2).
[106] Sec. 153.06 (1), (2).
[107] Sec. 153.06 (3).
[108] Sec. 153.06 (4).
[109] Sec. 153.08.

Legal Limitations on Licensure to Treat the Sick

ONLY persons licensed to practice medicine and surgery are comprehensively trained, and may use any modality they choose in the treatment of the sick. All other licentiates are limited in the scope of their practice.

Use of the Title "Doctor"

Section 147.14 (3), Wis. Stats., 1941, provides that:

> No person not possessing a license to practice medicine and surgery, osteopathy, or osteopathy and surgery, under section 147.17, shall use or assume the title "doctor" or append to his name the words or letters "doctor," "Dr.," "specialist," "M. D.," "D. O." or any other title, letters or designation which represents or may tend to represent him as a doctor in any branch of treating the sick.

In addition to physicians and osteopaths, who are expressly mentioned in the above statute, only those licensed to practice dentistry, by virtue of express statutory permission, may use the title "doctor"[1] in the field of treating the sick.

The attorney general over a period of many years has ruled that the use of the title "doctor" alone, or in combination with any other phrase, whether modifying in character or not, is barred to all but those licensed to practice medicine and surgery, osteopathy and surgery, or dentistry. Optometrists, while not engaged in the practice of medicine,[2] are engaged in treating the sick, as they themselves conceded in asking to be excluded from the requirements of the basic science law;[3] the use of the title would effectively misrepresent their qualifications for they are but skilled tradesmen.[4] Chiropodists are entitled to use the designation "R. C.,"[5] but they are not "doctors." Masseurs are registered with the State Board of Medical Examiners and use the designation "R. M.," indicating that they are registered masseurs, but they are not "doctors," nor may they otherwise classify themselves.

The supreme court of Wisconsin has upheld numerous opinions of the attorney general ruling that the Wisconsin law forbids the use of the title

"doctor" by chiropractors. In a recent opinion[6] by Chief Justice Rosenberry, the court held that such use:

> . . . would tend to lead the public to the conclusion that persons so announcing themselves were qualified physicians, surgeons, or osteopaths as well as chiropractors. The situation is not aided because as was stipulated the defendant claimed he explained to his patient the nature of his treatment before administering it. *The title does not aid him in the treatment, it merely aids him in securing the confidence of prospective patients and in inducing people to apply for treatment* . . . (Italics ours)

Chiropractors

"Chiropractic" is defined as:

> . . . The adjustment of, ordinarily, the spinal column, and ordinarily only by manipulation by the hand; also, that chiropractic does not include the use of any medicines or drugs, nor surgery, nor the use of any devices which do other than adjust, if, indeed, it permits mechanical apparatus even for adjustment.[7]

Chiropractors have advertised themselves as devoted to a theory that their practice is "a philosophy, science and art of things natural; a system of *adjusting* the articulations of the *spinal column, by hand* only, for the correction of the cause of disease. This definition is inclusive and any and all other methods are declared not to be chiropractic. All else belongs to other methods."[8]

Licensed only as chiropractors, the practice of these cultists is limited to chiropractic. This is a proper ruling, since to "permit them to do more than that is to turn loose a group of incompetents in the use of methods for which they are incompetent, and work a hardship on the public."[9]

Restrictions on Chiropractic Practice.—Chiropractors in Wisconsin are not available for the treatment of workmen's compensation cases, for a chiropractor "is not a physician as that term is used in the (compensation) act and in chapter 147."[10] One licensed only as a chiropractor in Wisconsin, who uses electrotherapy in the course of treatment violates the Medical Practice Act.[11] Nor can chiropractors administer medicines or drugs, nor use any therapeutic methods other than adjustment of the spinal column by hand.[12] Chiropractors are not privileged to disregard the quarantine of communicable diseases, as they are not physicians under the Wisconsin law.[13] A chiropractor is not permitted to perform electrocoagulation of the tonsils.[14] Not being a physician, he cannot sign death certificates,[15] or, by analogy, other health records.

Osteopaths

Osteopathy is frequently defined as a form of "manual treatment of disease." It is a system of therapy without the use of drugs, based on the theory that diseases are chiefly due to mechanical derangement in the structure of the human body, which can be remedied by manipulation.[16]

Applicants in this particular field, who demonstrate the necessary qualifications, have been licensed since 1916 to practice osteopathy and surgery. A person licensed before 1916 to practice osteopathy alone is licensed to practice surgery upon presenting satisfactory evidence of having completed the course in surgery at a reputable osteopathic college, requiring not less than twenty months' actual attendance, and the regular examination of the board in surgery, and upon being found qualified by six members of the Board of Medical Examiners.[17]

Under the accepted principle that osteopaths are licensed to practice only "osteopathy and surgery" and not "medicine and surgery," the attorney general has issued numerous opinions confining the practice of osteopathy to its own system or philosophy of treating the sick.[18] Thus it has been ruled by the attorney general that an osteopath cannot prescribe medicines except those necessary as a part of an actual surgical operation.[19]

Persons licensed to practice osteopathy and surgery may not enlarge the legal scope of their activities merely by undertaking to perform functions properly belonging to the practice of medicine alone. Since vaccination, and the use of serums, antitoxins and the like is a form of preventive medicine, an osteopath is forbidden their use in his practice, for, according to the attorney general, "The point is that if an osteopath is qualified to practice medicine he may become licensed to do so . . ."[20]

It follows from this line of reasoning that osteopaths, not being licensed to practice medicine, cannot give the "medical examinations" required in cases of admission to state sanatoriums and county tuberculosis hospitals,[21] nor can an osteopath certify to the Wassermann examination as required under the Wisconsin marriage laws.[22] Under a recent opinion of the attorney general, osteopaths may not give injections for arthritis, although they may administer rectal anesthetics, if licensed in surgery, in connection with an operation.[23]

Masseurs

One licensed to practice massage or hydrotherapy is authorized to practice in those two fields, or in educational gymnastics, but not to treat a specific disease, except upon the advice of a licensed medical physician.[24] Massage has been defined as "a system of remedial treatment consisting of manipulating a part or the whole of the body with the hands or by mechanical means," while hydrotherapy is the use of water for therapeutic purposes.[25] An opinion of the attorney general used the following definition: "a method of rubbing, kneading, or stroking of the superficial parts of the body by the hand or an instrument, for the purpose of modifying nutrition, restoring power of movement, breaking up adhesions, etc., and hydrotherapy is the treatment of disease by means of water."[26]

It has been held that one giving athletic rubs in a club in connection with athletics or physical exercise is not required to be licensed to practice massage or hydrotherapy as such a license is applicable only to the practice of massage for therapeutic purposes. The attorney general has more recently held, however, that a massage parlor for reducing purposes only must be operated by one licensed as a masseur.[27]

Midwives

A midwife is not authorized to use any instruments, except to sever the umbilical cord, and may not assist childbirth by artificial, forcible or mechanical means. The performance of version, removal of adherent placenta, is likewise forbidden her as is the administering, prescribing, advising or employing of any drug, herb or medicine other than disinfectant and ergot after redelivery of the placenta. A midwife is unauthorized to practice medicine, surgery or osteopathy, or assume any title or designation tending to show that she is a practitioner of medicine or by law so recognized or authorized to grant any medical or death certificate.[28]

A midwife is further restricted from giving prenatal care.[29]

Optometrists

The practice of optometry is the employment of any means, other than the use of drugs, for the measurement of the powers of vision and the adaption of lenses, prisms and mechanical therapy for the aid thereof.[30] It is a mechanical trade not a profession. The legislature "has dealt with optometry as a skilled calling, not as a profession involving a relation of special confidence between practitioner and patient."[31]

Chiropodists

The practice of chiropody permits the diagnosis or mechanical or surgical treatment, or treatment by the local application of drugs, of abnormal nails or superficial excrescences on the hands and feet, such as corns, warts and callouses, or fissures and bunions; the diagnosis or mechanical but not surgical treatment of congenital or acquired deformities of the feet, but *does not* include surgical operations upon the hands or feet for congenital or acquired deformities or conditions requiring the use of an anesthetic other than local. It *does not* permit incisions involving structures below the skin, nor of any portion or organ of the body above the feet, except that the diagnosis and mechanical treatment shall include the tendons and muscles of the lower leg in so far only as they are involved in the enumerated conditions of the feet.[32]

Enforcement

The 1941 Wisconsin Legislature transferred the obligation of enforcing the Medical Practice Act from the State Board of Health to the State Board of Medical Examiners.[33] Funds for enforcement of the Medical Practice Act are now secured from the $3 annual registration fee provided for by Section 147.175, which was enacted in 1943.

Anyone violating any provision of the Act "shall be fined not less than one hundred nor more than five hundred dollars, or imprisoned not less than sixty days nor more than one year, or both."[34]

Citations

Note: All references below, beginning with the abbreviation "Sec.," are from the designated chapters and sections of the 1943 Wisconsin Statutes. References containing the abbreviation "Wis." are from the designated volume and page of decisions of the supreme court of Wisconsin. All references containing the abbreviations "Atty. Gen." are from the designated volume and pages of the official opinions of the attorney general of Wisconsin.

[1] Sec. 152.02 (1).
[2] State ex rel. Harris v. Kindy Optical Co. 235 Wis. 498, 501.
[3] Sec. 147.01 (1), (a), (b); 147.01 (2)
[4] State ex rel. Harris v. Kindy Optical Co. 235 Wis. 498, 501.
[5] Sec. 154.01 (2).
[6] State v. Michaels, 226 Wis. 574, 579, 580.
[7] 21 Atty. Gen. 646, 651; 29 Atty. Gen. 420, 421.
[8] Advertisement of Wisconsin Chiropractic Association, Appleton Post Crescent, October 6, 1931.
[9] Statement of B. J. Palmer, of Davenport, Iowa, founder of chiropractic, to the attorney general of Wisconsin, September 6, 1932.
[10] Corsten v. Industrial Commission, 207 Wis. 147, 148.
[11] 21 Atty. Gen. 646, 652.
[12] 29 Atty. Gen. 420
[13] 7 Atty. Gen. 68, 69; 14 Atty. Gen. 442.
[14] 17 Atty. Gen. 318, 319.
[15] 16 Atty. Gen. 95.
[16] Herzog, Medical Jurisprudence, Sec. 121, and Arnold v. Schmidt, 155 Wis. 55, 61.
[17] Sec. 147.17 (1).
[18] 10 Atty. Gen. 837; 29 Atty. Gen. 148.
[19] 14 Atty. Gen. 231; 18 Atty. Gen. 6; 19 Atty. Gen. 594; 21 Atty. Gen. 137, 163.
[20] 29 Atty. Gen. 148, 153.
[21] Chap. 50, Wis. statutes.
[22] Sec. 245.10.
[23] 29 Atty. Gen. 420.
[24] Sec. 147.185.
[25] Herzog Medical Jurisprudence, Sec. 125, 128.
[26] 28 Atty. Gen. 685–686.
[27] 26 Atty. Gen. 61; 29 Atty. Gen. 297.
[28] Sec. 150.04 (3).
[29] 26 Atty. Gen. 236.
[30] Sec. 153.01.
[31] State ex rel. Harris v. Kindy Optical Company, 235 Wis. 498, 501.
[32] Sec. 154.01 (1).
[33] Sec. 147.13 (6).
[34] Sec. 147.21.

Reciprocity Licensure Rules

THE following are so much of the rules adopted in January, 1945, by the Wisconsin State Board of Medical Examiners, as relate to licensure by reciprocity:

Rule 1. The applicant for license to practice medicine and surgery in this state without examination and by reciprocity shall furnish to this Board as a part of his application the statement of the examining board of the state in which he was licensed listing the professional subjects in which he was examined by such Board and the grade received by him in each subject.

Rule 2. Such applicant shall also present a certificate of registration in the basic sciences issued to him by the Wisconsin State Board of Examiners in the Basic Sciences, and satisfactory evidence of having completed a premedical education, including college courses in physics, chemistry, biology, and either German or French, the equivalent of the premedical course at the University of Wisconsin.

Rule 3. If the professional college from which the applicant is graduated does not require for graduation a hospital interneship of at least twelve months in addition to a four year course, such applicant shall also present satisfactory evidence of completion of such interneship in a reputable hospital.

Rule 4. Such applicant shall also present satisfactory evidence of one year of active practice; provided, however, that a year of residency or a second year of interneship, performed in a state other than Wisconsin, shall be accepted in lieu of such one year of active practice.

Rule 5. Such applicant shall also appear personally before the Board and submit to oral examination in which he must receive an average grade of 75.

Rule 6. Such applicant shall also present satisfactory evidence of good moral and professional character.

Rule 7. This Board approves and recognizes as reputable professional colleges under section 147.17 of the revised Statutes of this state, the medical schools recognized and approved by the Council on Medical Education and Hospitals of the American Medical Association at the time of the graduation of the applicant therefrom.

Rule 8. This Board approves and recognizes as reputable hospitals for interneship under section 147.17 of the revised Statutes of this state, the hospitals recognized and approved for interneships by the Council on Medical Education and Hospitals of the American Medical Association at the time of the applicant's interneship therein.

Rule 9. The fee to be paid by the applicant for license to practice medicine and surgery without examination shall in all cases be not less than the reciprocity fee of the state whose license the applicant presents, and in no case less than $50.

Rule 10. An honorably discharged surgeon of the Army or Navy or the federal health service may be licensed without written examination upon filing of a sworn and authenticated copy of his discharge and compliance with the other provisions of this section.

Rule 11. The provisions of this section, with reference to hospital interneship and premedical education, shall not be applied retroactively so as to bar an applicant who graduated prior to the adoption of these requirements.

Rule 12. The application for license to practice medicine and surgery without examination and by reciprocity shall be in the form prescribed and on blanks provided by the Board.

Application blanks can be secured from Dr. C. A. Dawson, Secretary, Wisconsin State Board of Medical Examiners, River Falls, Wisconsin.

Legal Status of Internes, Externes, and Residents

BEFORE discussing the legal status of internes, externes, and residents, it is first necessary to consider the definition of the terms, as used in Wisconsin. Little help in answering this question can be gained from the medical licensure act, chapter 147. The act makes no mention whatsoever of externes or residents and only briefly refers to internes. The term "interne" is generally understood to apply to one who is engaged in a twelve-months' period of advanced study and apprenticeship immediately subsequent to the completion of his college course and prior to the granting of his license. Section 147.15 makes it a prerequisite for granting of a license to practice medicine and surgery. The term, however, is sometimes loosely applied to the second and third year following the completion of the required period of interneship, during which similar studies are continued. *But after the first year, unless his medical school requires a longer interneship as a condition of graduation, the interne must be licensed and have the legal status of a practicing physician.* The practical effect of the statutes is to recognize, as within a proper educational sphere, a requirement that a medical student must undertake an interneship as a condition of graduation, but at the moment that the educational requirement of interneship is satisfied the individual is thereupon subject to all the licensure provisions of the Wiscon-

sin statutes. In this discussion then, "interne" will be limited to those in the first year of interneship.

The term "externe" is professionally applied to those advanced medical students *who have not as yet reached the interne stage, or been licensed to practice medicine*, but who are performing certain assisting and observing functions, either during a vacation period or during their fourth year of medical study, under the supervision of a licensed physician. Externes enter into this course of training under an arrangement between supervising physicians and the medical school. The hospital has no jurisdiction over them.

The term "resident" is generally applied to postgraduate medical students who have completed their required year of interneship and are doing what really amounts to advanced interneship work.

It is apparent then, that neither externes nor internes have the full legal status of licensed practitioners. Accordingly, the scope of their functions is correspondingly more confined. Their legal status has never been specifically passed upon by the courts, nor has the legislature seen fit to define their powers and duties, the matter being left entirely in the hands of the medical profession. That an interne has certain functions of a medical nature which he is permitted to perform is recognized by the Wisconsin Supreme Court, in the case of Nickley v. Eisenberg, 206 Wis. 265. The court there admitted that internes are not subject to the medical practice act, in that they may perform "such duties as are usually and ordinarily performed by them." It gave tacit recognition to the accepted practice performed by internes, pointing out that the legislature considered it essential to their professional training. In the same opinion, the court recognized the legal status of certain nurses who were not registered under chapter 149. By the same reasoning, externes would probably have a recognized status in the medical profession. But their status is such that neither internes nor externes are within the provisions of the so-called "privilege statute" under the case of Borosich v. Metropolitan Life Insurance Company, 191 Wis. 239.

The further question arises as to those responsible for mistakes made by internes or externes while performing their customary duties. That they are personally responsible for their negligence, is, of course, conceded, and this liability may extend to physicians under whom they are working or to the hospital employing them. The law generally holds the interne to be an employe or servant, inasmuch as he is obliged to spend his days and nights at the hospital to render any administrative or medical service provided by the hospital through its agents within the range prescribed by propriety and custom. This interpretation of his position is recognized by the courts under the workmen's compensation act, which extends employe protection to internes injured in the performance of their duties in the hospital.

Wisconsin has held that the hospital is responsible for liability arising out of the acts of internes in the performance of duties which are customarily performed by them. Exemption, however, has been made in the case of charitable hospitals which are protected by law for the acts of their employes or servants. See Schumacher v. Evangelical Deaconess Society, 218 Wis. 169; and Kuglich v. Fowle, 185 Wis. 124. However, where the interne is acting under the direct supervision of a physician or surgeon during the course of an operation, the hospital is absolved from responsibility and his acts become those of the surgeon or physician who has charge of the work.

An externe, as was pointed out, is generally an assistant of a physician and has no relationship to the hospital. Because the duties delegated to an externe by a physician are generally very much limited, extending only to observation, a situation would seldom arise in which an act of an externe might cause injury. A physician would presumably have the duty to see to it that the externe be delegated no duty which would call for discretion or judgment on his part, but should he be negligent, the responsibility for his acts would doubtless be that of the physician.

A "resident" in an institution or hospital, is required to hold a license to practice medicine (26 Atty. Gen. 504), and is as fully responsible for his acts or omissions as any other practitioner.

MARK IT ON YOUR CALENDAR!

All Wisconsin physicians are requested to make note of the fact that the 1946 Annual Meeting of the State Medical Society will be held in Milwaukee, October 7–8–9. The general scientific program is being arranged by E. R. Schmidt, Madison; C. D. Neidhold, Appleton, has charge of the scientific exhibits; and section scientific meetings are being planned by the following chairmen: R. M. Kurten, Racine, *Hospital Relations*, Chester M. Kurtz, Madison, *Internal Medicine and Cardiology;* Benjamin E. Urdan, Milwaukee, *Obstetrics and Gynecology;* F. H. Haessler, Milwaukee, *Ophthalmology & Otolaryngology;* L. V. Littig, Madison, *Radiology;* and Anthony R. Curreri, Madison, *Surgery.*

There will be eighty technical exhibits and thirty scientific exhibits to supplement the scientific information presented through the medium of scientific papers and motion pictures.

The New Wisconsin Public Assistance Law

CHAPTER 585, Laws of 1945, repealed all of Chapter 49 of the revised statutes (Relief of Poor) and re-enacted it into a co-ordinated public assistance code including in this new chapter the provisions as to aid to the blind and aid to dependent children. The new law made a number of substantial changes and among other things removed the stigma of pauperism by specifically defining persons entitled to assistance and what is meant by relief.

A dependent person is one without the present available money or income or property or credit or other means by which the same can be presently obtained, sufficient to provide the necessary commodities and services as are reasonable and necessary under the circumstances to provide food, housing, clothing, fuel, light, water, medicine, medical and surgical treatment (including hospital care), nursing, transportation, and funeral expenses.

Every municipality is required to furnish relief to all dependent persons therein and it is the duty of every municipality to establish or designate an official or agency to administer relief.

A new classification is created known as state dependents. These are persons who do not have a legal settlement in any county and who have resided in the state for less than a year. The state is required to reimburse the counties for all assistance given by the county to persons coming under the classification.

As to other persons, the law has made changes in the requirements of legal settlement for the purpose of treating assistance on a family unit basis rather than on an individual basis. A wife has the settlement of her husband if he has any within the state but if he has none, she has none. Legitimate children have the settlement of their father if living or of the mother if she is living and the father is deceased, but if the parents are divorced the children have the settlement of the parent who has legal custody and if such has no settlement, the children have none. Illegitimate children have the settlement of their mother unless her parental rights are terminated and if her settlement is lost, theirs is lost. A minor who marries acquires a settlement in his own right and loses that of his parents or parent.

A new option as regards the provision of medical care by counties not on the county system of relief was established permitting the provision of medical and surgical care for recipients of old-age assistance, aid to dependent children, and aid to the blind by the county through the agency administering those programs even though the medical care for other people needing general relief would still be handled by the local units. This option is in addition to the other two existing options which were continued and which permit the counties to administer general relief under a county system or permit the county to administer all medical and hospital care on a county basis while leaving to the municipalities the responsibility for providing other items of general relief such as food, clothing, and shelter.

Under the law the county may receive reimbursement from the state in the amount of 35 per cent of its expenditures for direct payment of hospital and doctor bills for recipients of the social security aids providing the county board exercises the option available under the law. Heretofore the only way that the state participated in such payments was for aid to dependent children to the extent of 33⅓ per cent and through the inclusion of the amount necessary for the payment of such bills in the grants to recipients of old-age assistance and blind pension.

The eligibility period for aid to dependent children is reduced from one year to three months after divorce or abandonment by the father.

A dependent eligible for old-age assistance must have attained the age of sixty-five years and have resided in the state continuously for one year preceding the date of application. However, an applicant who has not resided the required year in Wisconsin may be granted old-age assistance if the state from which he removed his residence to Wisconsin grants assistance to any resident in Wisconsin who has moved to such state and lived there less than one year.

The law as to emergency hospitalization and medical and surgical care has been amended so that the hospital or physician has forty-eight hours rather than twenty-four hours to give notice to the unit administering assistance of the care given where there is not time to seek authorization prior to the need for service.

The previous law as to the relief of the blind provided that the County Board should appoint a regular practicing physician whose duty was to examine all applicants for pensions and peddler's license. The new law provides that applicants for aid to the blind shall be examined by a physician skilled in eye diseases who shall receive a $2 fee for the examination unless the County Board establishes a larger fee. However, an applicant for a peddler's license must pay for his own examination, the fee for which shall not exceed $2.

As regards the social security aids themselves, fundamental changes in aid to the blind include authorization of direct payment to doctors and hospitals for medical and hospital care with state participation, reduction of the residence requirement to one year, and a provision that the maximum amount of aid may be increased to $50 whenever federal aid for such purpose is made available.

The procedure for processing inter-county and inter-municipality claims has not been greatly changed.

Physicians and the Workmen's Compensation Act*

THE workmen's compensation act is designed to afford a measure of protection to the working men of the State of Wisconsin. The law, not applicable to farmers, affects employers who, in the course of a business, trade, profession, or occupation, usually have three or more employes. Benefits are provided an employe sustaining an injury or disease in the course of his employment. It has been stated frequently that all but the employer and the employe are strangers to the act and are unaffected by its provisions. Strictly, this is true. However, when a workman files a claim before the Industrial Commission alleging that he is entitled to benefits under the workmen's compensation act, the commission acquires functions that affect the relationship of the physician and his patient as well as the lawyer and his client.

As has been pointed out previously, many more physicians are constantly coming into contact with the procedures and practices of the Industrial Commission, and because inquiries are frequently directed to the State Medical Society regarding the act and the scope and effect of its provisions, this statement is prepared as a summary of some of the more important aspects of the law. While it has not been drafted by or at the suggestion of the Industrial Commission, it has been submitted to the commission and incorporated in it are the thoughts and suggestions of its staff members.

The panel system. Prior to the legislative session of 1939, the workmen's compensation act provided that employers of three or more employes could not be required to maintain a panel of more than five physicians from among whom the injured employe might make his choice of attendant. The panel must be furnished even though in some instances the only physicians available are not members of the State Medical Society of Wisconsin. The Society, in cooperation with associations representing both stock and mutual insurance companies writing compensation insurance in the State of Wisconsin, undertook to enlarge the panels through the voluntary cooperation of employers and insurance carriers, in an effort to give the workmen of this state an opportunity to secure virtual free choice of attendant. Through this cooperative effort approximately 80 per cent of the workmen of this state, subject to the compensation act, thus have available to them virtual free choice of physician.

In the 1939 legislative session, the statutory limitation as to the required size of the panel was repealed, and the Industrial Commission was given the authority to determine the proper size of the panel through general orders or special orders applicable to given communities. But this amendment does not affect the agreement executed between the State Medical Society and the insurance carriers, under which a conference committee composed of both physicians and insurance company representatives was established. While the committee's responsibilities are manifold, it is important to the physicians who are members of this society that they may avail themselves of the services of that committee as an arbitration medium.

It is contemplated that the committee will function so as to reduce the differences that may arise between the insurance companies and the physician relating to the method of treatment of an injured workman, the charges made by the physician, and similar questions. Conversely, the insurance companies have the opportunity of referring to the conference committee for arbitration situations in which insurance company officials may be of the opinion that the physician's charges have been excessive or in which the physician has neglected to supply the company with the information to which it is properly entitled.

No formality is required in the cases where either the physician or the insurance companies may have a matter to report relative to the handling or disposition of compensation cases. The secretary of the State Medical Society should be informed of the general nature of the complaint and further information, if necessary, will be acquired that the committee may function to the best advantage possible.

While the committee does not meet regularly, its meetings are comparatively frequent, and questions of policy and of the application of the workmen's compensation act are being continually referred to it.

Under the law, of course, the employer is required to post the panel physicians available for treatment just as it is primarily his duty rather than that of his insurer, if he has one, to provide medical care. If the employer fails to do this, the effect of certain supreme court opinions is to hold that the injured workman has absolute free choice of physician. The medical panels of those employers whose insurance is carried by insurance companies participating in the open panel agreement with the State Medical Society are made up only periodically, and so far it has not been necessary to revise these oftener than once each year. A physician who desires to participate in panel listing and who is not now listed may apply to the Society. In applying to the Society, the physician agrees that if he is listed on the panel and engages in treating

* Reprint (with some corrections and alterations) of pamphlet issued by State Medical Society, June 15, 1940, to its membership. For much of the material the State Medical Society is indebted to Mr. Harry A. Nelson, Director, Workmen's Compensation, Wisconsin Industrial Commission.

compensation cases, he will call a consulting physician into the case upon request of the insurance carrier. [It is expected that the physician will communicate with the insurance carrier as to the choice of consultant.]

The members of the State Medical Society should keep in mind that the effort of their Society and the insurance carriers is to provide physicians able and willing to treat compensation cases and to assure to those workmen entitled to the benefits of the act what amounts to a free choice of attendant.

Benefits of the act. The workmen's compensation act is an attempt to provide injured employes reasonable recompense for injuries or diseases received during the course of their employment and to provide them with such medical attention as may be necessary to accomplish the utmost in rehabilitation. The law imposes a liability upon the employer to provide certain indemnities and to provide or pay for necessary medical attention. Because it is in the nature of a liability, those concerned with the compensation act, while they are liberal in its construction, must find three essential elements to exist in order to justify an award to the injured claimant: (1) employer-employe relationship; (2) employer subject to the act; and (3) injury or disease suffered or acquired in the course of employment. With reference to medical care, the workmen's compensation act provides that employers subject to the act must supply any injured employe with "such medical, surgical and hospital treatment, medicines, medical and surgical supplies, crutches, artificial limbs and appliances . . . as may be reasonably required to cure and relieve from the effects of the injury. . ."

Collection of physician's account. It is important to keep in mind that there may be one of two, or two, sources from which the physician may be paid for his services rendered an injured workman entitled to benefits under the act. If the employer himself authorizes the physician to treat the injured workman, then the employer is directly liable to the physician for the expense of that treatment, and that liability continues until such time as it is terminated by the employer's objection to further medical care at his expense.

If, on the other hand, the injured employe himself requested the treatment, without authorization from the employer, then the physician must look to the injured employe for payment, except ordinarily he can expect the Industrial Commission to determine the amount thereof for which the employer is responsible. Where the employer fails to furnish a panel, the injured employe has complete free choice, and the Industrial Commission has power to determine the reasonable necessity for treatment and the reasonable amount of the medical bill for which the employer is responsible. In cases where the employe has not given notice of necessity for treatment or has refused to accept a panel physician, the employer has no liability and the commission no jurisdiction to determine necessity or reasonableness but may, upon claimant employe's request, direct payment to the physician of what appears to be a reasonable amount for necessary treatment.

Physician-patient relationship maintained. Generally, of course, communications to an attending physician are privileged and may not be communicated by him. The workmen's compensation act creates an exception to the general law of privilege as any physician, having attended an injured employe who files a claim under the workmen's compensation act, may be required to testify before the commission when it so directs. With reference to this the commission says: "It is a practical necessity that the physician attending the injured workman furnish information to the Commission upon which to base compensation. Physicians will not be required, however, to disclose confidential communications commuted to them for the purpose of treatment and which are unnecessary to a proper disposition of the claim. The Commission regards the physician who treats the injured workman at the request of the employer, to all intents and purposes, the physician of the injured man. His testimony before the Commission should be absolutely fair and unbiased."

The physician acting as expert witness for injured claimant. Not infrequently, of course, the claim of an injured workman that he has suffered injury in the course of his employment for which he is entitled to compensation is disputed by the employer or the compensation carrier of the employer. The members of the State Medical Society have no interest, of course, in the technical questions of fact and law which involve other than medical questions. They are interested, however, (regardless of whether they may be the attending physician or an expert witness for either the injured workman, or the employer or his insurance company) in the fact that the basis of any claim must depend upon whether the injury or disease was suffered in the course of employment.

In many cases the fact of the injury or disease being suffered in the course of employment is accepted by the employer or the insurance company, and the question then is confined to the extent of liability on the part of the employer. In the fields of industrial disease, or diseases attributable to a given occupation, the physician must be prepared to relate the disability to the employe, if such be the case.

Where the claim is controverted by the employer or insurance company either as to causative factor or as to extent, the injured workman frequently calls upon a physician other than the attending physician to appear as an expert witness in his behalf. In such case, the physician must make a careful study and examination of the whole question and be prepared to present his opinion adequately and carefully.

The State Medical Society has received many inquiries raising the question of how the expert witness is paid and to what extent. Before discussing this question in its many implications, certain basic concepts of the workmen's compensation act must be kept in mind. Of primary consideration the claimant must first establish: (1) the employer-employe relationship with both employer and employe subject to the act, and (2) the fact of an injury or disease sustained or acquired by the claimant in the course of such employment.

Second, as stated elsewhere in this memorandum, the employe is entitled, in event of injury and an award therefor, only to recompense for the injury and for the cost of treatment. The award may not be frivolous or capricious and is governed by the strict formula provided in the act itself. The award, or the jurisdiction to grant one, does not involve the unlimited field of a personal injury action but is strictly governed by statutory limitations.

In the third place, it is conceived as the function and responsibility of the Industrial Commission to protect the injured claimant in every proper way. For example, the law does not provide that applicants must be represented by attorney in hearings before the commission, but that they may appear in person or by agent or attorney. When they appear without attorney, the commission undertakes to do everything possible to assure a fair and impartial hearing. By statute, furthermore, the commission has authority to determine the reasonableness of attorneys' fees rendered by attorneys representing the claimant. By express provision of law, it is illegal for an attorney to charge in any case more than 10 per cent of the award on a contingent basis or a maximum of $100, unless the commission has first authorized such a charge. The commission is authorized, in the interest of a fair and impartial hearing, to order examinations by physicians who are wholly independent of either the claimant, the employer, or the insurance carrier. Such physicians become witnesses of the State of Wisconsin at the time they appear to testify relative to the claim of the injured workman.

Finally, the commission directs attention to the case of Philler v. Waukesha County, 139 Wis. 211, to the effect that expert witnesses may not require payment in excess of statutory fees unless work is performed in preparation at the request of a party. The question frequently arises as to whether a physician must obey a subpoena when ordinary witness fees only are paid. Many physicians believe that they cannot be required to do so unless an expert witness fee is paid to them. Our court, however, has held that except as there may be a demand for preparation, etc., every witness, whether expert or otherwise, must obey a subpoena upon payment of ordinary witness fees.

Because it so frequently deals with the question of physicians' fees, both those in connection with treatment in the case or as an expert, the commission and its staff tend to establish certain levels in the professional work of such physicians. In the case of physicians who are called by the commission as independent expert witnesses or for the purpose of simply making an examination and report, the Industrial Commission has an established fee schedule under which the services are rendered. This fee schedule is set out under rule 13 and is as follows:

> "Unless otherwise specifically agreed, services of physicians and surgeons rendered at the request of the Commission shall be understood as contracted for on the following terms:
>
> | | |
> |---|---|
> | Minor examination and report, not to exceed | $ 5.00 |
> | Major examination and report, not to exceed | 10.00 |
> | X-rays where necessary to foregoing examination and report, not to exceed an additional | 5.00 |
> | Attendance at hearings on request of Commission: | |
> | for first hour | 10.00 |
> | for each additional hour | 5.00 |
>
> Claims for such services must be paid from the Commission's appropriation and should be submitted on official voucher blanks."

These fees do not, of course, govern the contractual relation between the physician and the claimant, and the physician and the employer, where the physician is called as the expert witness of either. But in those cases in which the physician appears as an expert witness for the injured employe, and seeks to have his fees paid directly out of the compensation award, it must be expected that the Industrial Commission will endeavor to protect the employe through permitting only what it considers to be a reasonable allowance for the expert. Each bill necessarily depends on the circumstances of the individual case, but the State Medical Society suggests to its members the practical necessity of submitting itemized statements substantiating the charges made by the expert witness.

With an itemized statement before it, the Industrial Commission is in a better position to judge of the work involved and of the reasonableness of the charges of the physician.

In the case of state employes who file compensation claims, the commission is explicit in its demands for itemized medical statements and for verification of the reasonableness of the charge:

> (Rule 18)
>
> "No claim for compensation or medical aid by an employe of the state will be allowed until the following reports and statements have been furnished to the Commission:
>
> "(2) A sworn statement by the injured employe to the effect that he was injured in the course of his employment and reciting the time and place of the injury, the reasons for its occurrence, and the nature of the injury, and also setting forth *in detail* the expenditures

incurred for necessary medical, surgical and hospital treatment and medicines, (if these bills were paid by the injured, receipts must be attached) . . .

* * *

"(4) A sworn statement from the physician and the hospital itemizing the service rendered and the charges therefor . . .

* * *

"(5) A letter from the employing department, stating its recommendations upon . . . (b) the necessity for the medical, surgical and hospital treatment, (c) the reasonableness of the bills incurred for such treatment and for medicines; . . ."

Physicians should submit their reports promptly to the commission. Delay may mean the withholding of compensation to the injured employe and of professional fees to the physician.

Physicians must keep in mind the fact that where an appearance as an expert witness is made for a claimant and no award is granted, they must look directly to the employe for payment. Furthermore, where a physician treats an injured employe and such treatment has not been authorized by the employer, and the Industrial Commission finds no liability on the part of the employer, the physician must look directly to his patient for payment.

Estimating of Permanent Disability Under the Wisconsin Workmen's Compensation Act

With a general broadening of panels of physicians for the purpose of treating injured employes under the Wisconsin workmen's compensation act, it becomes desirable for physicians to have a clear understanding of the estimating of permanent disability under terms of the act. A study of the act as to benefit provisions, and particularly of the provisions of Sections 102.42, 102.43, 102.44, 102.52, 102.54, 102.55, 102.555, and 102.565, is recommended. Copies of the compensation act in pamphlet form are available and will be forwarded by the Industrial Commission to any interested physician upon request.

Under the provisions of the workmen's compensation act, injuries may be divided into two types for the purpose of estimation of permanent disability, i. e., nonschedule and schedule injuries.

Nonschedule injuries. Nonschedule injuries are those to some portion of the body other than the legs, arms, ears or eyes, or their constituent parts. Generally speaking, nonschedule injuries are to the torso or to the head, exclusive of eye and ear injuries.

In the case of nonschedule injuries permanent disability is based upon wage loss consisting of such percentage of the average weekly earnings of the injured employe computed according to the provisions of the compensation act "as shall fairly represent the proportionate extent of the impairment of the injured's earning capacity in the employment in which he was working at the time of the injury, and other suitable employments, the same to be fixed as of the time of the injury, but to be determined in view of the nature and extent of the injury." (Sec. 102.11(3) Stats.) If the disability is such as to render the employe unable to perform substantially all the material duties of his own occupation, or of any other remunerative occupation which his age, training, experience, education and physical condition would fit him for, except for his disabling infirmity, his disability is total. The Wisconsin Supreme Court has held that a man's wage earning capacity is to be distinguished from his capacity to make money in a business conducted under his supervision or direction, and with the use of investment of other capital than that which arises from his own labor. The question thus resolves itself into one of employability, using care to distinguish the nonemployability resulting from the employe's physical condition from that which results because of economic conditions or other circumstances which might limit employability regardless of the employe's physical condition. In the case of one who is fitted to perform labor only, a back injury of a certain severity may cause considerable wage loss, while in the case of one suited for clerical work the same physical disability, in terms of wage loss, would be much less serious. The limitation in capability to work within a limited field of employment must be considered in determining the percentage of impairment of earning capacity. With such double limitation the probability of wage being earned by the employe is obviously more largely curtailed, and probable wage loss is greater.

Schedule injuries. Schedule injuries are estimated upon a different basis, which bears no relation to wage loss. In these cases *the comparison is as between the injured limb and a normal limb*, having in mind all of the useful functions of the limb or organ. Schedule injuries apply to arms, legs, eyes and ears, as well as any constituent part of these members and organs. The estimate of disability takes no regard of any particular occupational use to which the member is to be put. The violin player who has lost a digit vital for the purpose of playing, and who may consequently lose much wage, receives exactly the same number of weeks' compensation as does the laborer who may be able to perform his work nearly as efficiently as before, even with the loss of a digit. The law fixes the value of each finger, thumb, toe, hand, arm, foot

and leg at various joints. In the estimation of disability the doctor takes into consideration the percentage of loss of function which has resulted to the given unit as of the joint at which disability exists, or if disability is between joints, at the joint proximal to the point of disability. For example, if there is disability proximal to the wrist, but no disability above the elbow, the comparison is of the arm with a normal arm at the elbow, or, put conversely, with an arm which has been *amputated* at the elbow.

Because in every case of schedule injury, where there is a certain limitation of motion with no other element of disability involved, the functional disability is the same as in all identical cases, the estimate in such cases should be uniform. If the employe has lost his ability to raise his arm at the shoulder beyond the horizontal level and has no other disability, the estimate should manifestly be the same in his case as in all other cases where the limitation of motion is identical and where no other disability has resulted.

In case of schedule injuries the commission has found it possible to establish by custom or rule the related disability applicable to a given handicap. After many hearings with physicians, and in cooperation with the State Medical Society, the commission has adopted a schedule of related disabilities to serve as a guide in rating disabilities *short of amputations or total loss of all function.* In the example cited, where the loss of function is represented by a limitation of active elevation of the arm in all directions to 90 degrees, but otherwise normal, *the loss is interpreted at 20 per cent of the arm at the shoulder.* In all of the cases where landmarks have been adopted, the percentage of disability must vary as other conditions exist which constitute elements of functional loss. *If, for example, in addition to limitation of motion, there is disabling pain or weakness, a percentage must be added for these elements.* As the commission has adopted landmarks only for loss of certain specified functions representing disability, the physician must exercise his best judgment as to the percentage to be added for other items which may conduce to disability.

As a guide for the estimating of disabilities the commission has adopted the following table *representing per cent of loss of use as compared with amputations at involved joints.*

Shoulder

Total ankylosis at the shoulder with arm at side, scapula fixed	75%
Total ankylosis at the shoulder with arm at side, scapula free	55%
Limitation of active elevation to 45° but otherwise normal	35%
Limitation of active elevation in all directions to 90° but otherwise normal	20%
Limitation of active elevation to 135° but otherwise normal	5%

Elbow

Ankylosis of elbow joint at 45° less than full extension (radio-ulnar motion destroyed, hand 45° less than fully pronated)	60%
Limitation of motion of elbow joint (radio-ulnar motion unaffected)	
Remaining range, 90°–135°	20%
Remaining range, 135°–180°	35%
Ankylosis of radius and ulna, estimated at elbow joint (hand 45° less than fully pronated)	20%

Wrist

Ankylosis, straight position	25%

Fingers

Complete ankylosis Thumb	Mid-position	Complete Extension
Distal joint only	25%	35%
Proximal joint only	15%	20%
Distal and proximal joints	35%	65%
Distal, proximal and carpometacarpal joints	85%	100%
Fingers		
Distal joint only	25%	35%
Middle joint only	75%	85%
Proximal joint only	40%	50%
Distal and middle joints	85%	100%
Distal, middle and proximal joints	100%	100%

Loss of Motion Fingers	Loss of flexion	Loss of use	Loss of extension	Loss of use
Distal joint only	10% =	1%	10% =	2%
	20% =	2%	20% =	4%
	30% =	3%	30% =	6%
	40% =	5%	40% =	8%
	50% =	10%	50% =	15%
	60% =	15%	60% =	20%
	70% =	20%	70% =	30%
	80% =	25%	80% =	40%
			100% =	60%
Middle joint only	10% =	5%	10% =	2½%
	20% =	10%	20% =	5%
	30% =	15%	30% =	10%
	40% =	25%	40% =	15%
	50% =	40%	50% =	30%
	60% =	50%	60% =	50%
	70% =	60%	70% =	70%
	80% =	70%	80% =	90%
			100% =	100%
Proximal joint only	10% =	5%	10% =	2½%
	20% =	10%	20% =	5%
	30% =	15%	30% =	15%
	40% =	20%	40% =	20%
	50% =	25%	50% =	25%
	60% =	30%	60% =	40%
	70% =	35%	70% =	75%
	80% =	40%	80% =	85%
			90% =	100%

(Where there is partial disability to two or more phalanges the estimate of the physician should take into consideration the greater cumulative effect because of such multiple disabilities. By analogy the allowances for complete ankylosis, where two or more joints are affected, may be used as a guide

for comparison as to the greater allowance to be made because of the combined disabilities to two or more phalanges.)

Hip

Ankylosis in alignment for normal standing position	50%
Shortening of leg (no posterior or lateral angulation, age 50 or less)	
1 inch	7%
1½ inches	14%
2 inches	22%

(The percentages compare loss of the leg at the hip.)

Knee

Ankylosis at 170°	40%
Limitation of motion, remaining range 135°–180°	20%

Ankle

Ankylosis—favorable position 10 to 15 degrees equinus without loss of inversion and eversion	30%
Ankylosis—favorable position with loss of inversion and eversion	40%
Loss of inversion and eversion with full dorsi and plantar flexion remaining	15%

Report form. For use in reporting disabilities under the compensation act, the commission has adopted forms for use of physicians.

In order to enable the commission to pass upon disability, it becomes necessary that the physician's report contain as a minimum all of the information requested by this form. If in any case use is not made of the form, the physician should make certain that the requirements of the form are met. That will save returning the form to the physician with request for supplementary report.

In addition to the regular form, the commission has adopted another form of physician's report under the new provision of Sec. 102.17 (1) (as), effective June 10, 1943, which provides that the contents of verified medical and surgical reports by physicians and surgeons licensed in and practicing in Wisconsin presented by claimants for compensation shall constitute prima facie evidence as to the matter contained therein, subject to such rules and such limitations as the commission may prescribe.

The purpose of this provision is to make it unnecessary for the physician to appear personally in some cases, especially where the issue in dispute is of a simple nature and it is desirable to avoid expense to the applicant in arranging for the personal appearance of the physician at the time of hearing.

In addition to these forms the commission also makes use of a form for use in cases of loss of vision, which will be supplied to physicians upon their request, together with rules for determining loss of visual efficiency caused by industrial injury. In the case of partial deafness, no fixed rule has been adopted for determination. The physician should make use of recognized standards in reaching an estimate as to the percentage of loss of hearing which has resulted.

Forms are available upon request to the Industrial Commission.

Estimates of Disability

Obviously methods of estimating must be in accordance with the law, regardless of the personal feeling of the physician as to the correctness or justice of the law. In general, parties are probably in agreement as to the essential justice of these provisions. However, physicians may at times have some doubt in individual cases as to the equity of one or other provision, or may feel that the law is harsh or inadequate from the standpoint of either employer or employe. That feeling should never be allowed to influence the physician, either in treating or in estimating disability.

The physician who estimates disability should, under no circumstances, concern himself with the result in number of weeks or in dollars but should confine himself strictly to the medical field in estimating the disability on a functional basis. The physician should never suggest that a case should be settled on a certain basis but should confine himself to setting out his pertinent findings. It is the function of the employer and carrier, not that of the doctor, to propose the basis for settlement. The doctor's function is to report his factual findings with the probabilities and possibilities which may be involved, leaving to the employer or carrier the suggestion as to whether or not settlement should be made and upon what basis. It is clear that if the physician is influenced by the amount of compensation which may be paid to the injured, his estimate will not be on a valid basis. Neither should physicians attempt to compute the amount of compensation to become due. The law fixes the amount to be paid on the basis of disability which has resulted. This amount may be much greater or smaller than one or another physician might consider to be equitable. Computation of compensation based on estimates of disability is a function for the Industrial Commission. Attempts of physicians to compute very often result in erroneous figures and thus cause confusion and misunderstanding, both on the part of the physician and the injured person.

In the estimating of disabilities to members included within the schedule group, it should be remembered that 50 per cent loss of motion, or 50 per cent loss of strength, of itself *does not necessarily mean 50 per cent loss of function of the limb.* All functions of the limb must be considered, such as motion, freedom from pain, strength, coordination, quickness of action, endurance, sensation, etc. To each factor must be assigned by the physician the percentage which he considers represents the proportion of functional use of that factor as compared with all functions of a normal member, and to each factor must be applied the percentage of loss of the particular factor which has resulted. The total of the resulting percentages constitutes the percentage of disability to the member involved.

In those cases in which loss of motion is greater or less than that represented by the landmarks

established by the commission, the physician must add or subtract such percentage as he believes will represent fairly the greater or smaller percentage of disability found to have resulted. In making his estimate the physician will be guided by the landmark laid down for the most nearly comparable disability for which a landmark has been established.

The cooperation of physicians is earnestly solicited by the commission in the making of prompt and complete reports to employers and insurance carriers, making it possible for them to pay compensation speedily and without interruption when due to employes. The commission feels that those physicians who, because of press of other business, or because of a lack of desire on their part to participate in the compensation program, find it impossible to do justice to the parties, or to make all necessary reports promptly, should not be included in panels for the purpose of treatment of injured employes. Physicians have it within their power to hasten or delay the payment of compensation which is clearly due. Time is of the essence under the workmen's compensation act in the payment of compensation to those who usually are in urgent need because of their unexpected misfortune.

In this connection it should be pointed out that many reports have to be returned to physicians because of use of terminology which does not follow that set out in the statute. For example, the statute refers to the thumb, index, middle, ring and little fingers, and to disability at the distal, second and proximal joints. Some physicians refer to the first, second, third and fourth fingers, and some designate the thumb as the first finger. Also some physicians speak of the interphalangeal joints, and sometimes of the first, second and third joints, leaving confusion as to the point of measurement. If physicians will use the language of the statute, a good deal of confusion and necessity for supplementary reporting can be avoided.

As it is the commission's ultimate function to fix the percentage of disability, full reports covering all factors should be made, setting out in detail the elements which constitute disability, and stating as nearly as possible the weight and percentage of loss which has been ascribed to each. The physician should also set out his opinion as to the ultimate total percentage of disability which has resulted. That enables the commission to check the report with the commission's standards and to arrive at an intelligent and uniform conclusion.

From time to time physicians propose certain standards or schedules for the measurement of disability. The commission wishes to call attention to the fact that no standards or schedules not adopted by the commission have the approval of the commission. Only those standards adopted and published by the commission itself should be considered as authoritative or as representing the commission's thought as to percentages of disability based on certain functional losses. It is appreciated that other schedules may be studied as a matter of interest by physicians who will undoubtedly wish to arrive at an opinion based upon their own examination and analysis and by reference to the standards which the commission has authoritatively adopted.

It has not been the purpose of this resume to conduct an exhaustive analysis of the law in the many ways in which it may be related to the physician and his patient. Many questions will doubtless remain in the physician's mind.

But if the panel physician will appreciate the technical detail of much of the law and its administrative characteristics, he will find it easier to deal with the employer, the insurance carrier, and the patient. Both the office of the State Medical Society and the Industrial Commission will be happy to be of assistance in the medicolegal problems confronting the physician who treats patients entitled to, or claiming, benefits under the act. Inquiries may be directed either to the State Medical Society or to Mr. Harry A. Nelson, Director of Workmen's Compensation, State Capitol Annex, Madison 2, Wisconsin.

SIMPLIFIED REPORT FORMS

As a means of lessening paper work on the part of physicians filing reports on compensation cases the Conference Committee on Open Panels has approved simplified and standardized report forms covering the Surgeon's First Report, the Progress Report, and the Final Report. All insurance carriers covered by the Open Panel Agreement have been urged to adopt the standardized report forms. If your report forms are still complicated and repetitious, contact the Conference Committee on Open Panels, through the office of the State Medical Society of Wisconsin, so that the insurance carrier requiring needlessly detailed reports can be contacted by insurance representatives on the Conference Committee and urged to adopt the simplified report forms used by other insurance carriers.

Agreement on Panel Practice

AT THE suggestion of the insurance companies selling workmen's compensation insurance in Wisconsin, the State Medical Society of Wisconsin entered into a joint agreement with them to permit employes eligible to benefits under the workmen's compensation act to have free choice of physician. Through the medium of this agreement any member of the State Medical Society of Wisconsin who indicates his willingness to serve injured employes may have his name included in the panel which is certified to the insurance companies. This agreement makes it possible for from 75 to 80 per cent of the employes in Wisconsin to have a wide choice of physician.

The attention of members is specifically called to the provision under the application for placement on panels that the member agrees to have consultation when so requested by the insurance carrier. The member also agrees to communicate with the insurance carrier in regard to the consultant in order that the consultant might be mutually agreed upon. It is recognized that exceptions will occur to this portion of the agreement, but the exceptions should occur only in the event of an emergency.

The agreement on panel practice in Wisconsin as adopted by the Council of the Society and the insurance company associations is as follows:

Agreement on Panel Practice in Wisconsin

The workmen's compensation law of Wisconsin requires all employers to maintain a panel of five physicians, from which an injured employe shall have the right to make choice of an attending physician in case of accident.* In many communities the common interests of the employer, the injured employe and of the medical profession will be more equitably served by liberalizing the minimum statutory requirement. In order to provide a larger medical panel from which the injured employe may select his attending physician, representatives of both the stock and mutual insurance companies writing compensation coverage in the State of Wisconsin, and representatives of the State Medical Society of Wisconsin, established the following principles:

1. The State Medical Society will prepare, and make available to insurance carriers, panels listing the names of all those physicians in each component county society desiring to accept employes eligible for treatment under the workmen's compensation act. This list and the panels will be kept as accurate as possible, but need not be revised more often than January 15 and July 15 of each year. If any panel distributed by an insurance carrier includes the names of any physicians not members of the State Medical Society, nothing thereon shall indicate that it has been approved by said Society.

2. A State Conference Committee of four, two representing insurance carriers and two representing the State Medical Society will be established, whose function it will be to coordinate the obligations of the insurance carriers with the facilities of the medical profession to provide proper benefits to injured employes. Specifically such committee shall have the duties of:

a. Mediating, if possible, those cases where the insurance companies complain that the attending physician has neglected or refused to furnish the reports reasonably necessary.

b. Mediating, if possible, those cases where it is complained that the insurance carriers have unreasonably interfered with what is properly in the discretion or control of the attending physician.

c. Reviewing any situation in which it is claimed that there has been a violation of medical ethics and, in its judgment, referring any facts relative thereto to the Board of Censors of the County Medical Society.

d. Mediating, if possible, differences that may arise between the attending physician and the insurance carrier relative to remuneration.

e. Hearing any complaints relative to the competency of those serving on such panels and removing their names therefrom if, upon investigation, it is found that such complaints are justified.

In the event of complaints from either insurance carriers or physicians the State Conference Committee may designate a special local committee to investigate and report to the State Conference Committee with recommendations as to the action to be taken. Both the State Conference Committee and the special local committees will attempt to mediate only those cases wherein the physician involved is on the listing provided by the State Medical Society.

3. It is understood that this is a trial plan and is necessarily limited to the State of Wisconsin. Any modifications of this general statement of principles to be effective must be approved by the State Conference Committee.

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* This provision of the original agreement is now obsolete, as the commission requires a "reasonable choice" of physicians in light of community medical resources and needs.

Privileged Status of Testimony of Physicians and Surgeons in Legal Proceedings

THE present law relating to privilege accorded the testimony of physicians and surgeons in Wisconsin courts is as follows:

325.21 **Communications to doctors.** No physician or surgeon shall be permitted to disclose any information he may have acquired in attending any patient in a professional character, necessary to enable him professionally to serve such patient, except only (1) in trials for homicide, . . . (2) in all lunacy inquiries, (3) in actions, civil or criminal, against the physician for malpractice, (4) with the express consent of the patient, or in case of his death or disability, of his personal representative or other person authorized to sue for personal injury or of the beneficiary of an insurance policy on his life, health, or physical condition.

This statute refers only to the testimony of a physician or surgeon in legal proceedings, and is to be distinguished from subsection (d) of section 147.20 (1), Wis. Stats., which provides for revocation of the license of a physician or surgeon for wilfully betraying a professional secret. Testimony within the protection of the statute includes information given by the patient in good faith, even when the physician or surgeon could have diagnosed and prescribed without it, and may include the physical circumstances of an injury and its occurrence, or the previous condition of an injured part of the body if, in the opinion of the physician or surgeon, such information is necessary to enable him to serve the patient.

The law relating to privilege is statutory and has no basis in the common law. Accordingly, the tendency of the court is to interpret the statute strictly and literally and to enforce only such restrictions as the statute specifically imposes, and not to add restrictions which the legislature may have omitted. As a result, certain interpretations and constructions of the statute have been made which are important to know.

For a long time the Wisconsin Supreme Court has adhered to the doctrine that a physician or surgeon may testify, or may be compelled to testify, to a condition observed by him when unconnected with treatment, even when the person observed or examined for purposes other than treatment is or was a patient of the physician. Following this principle the court has held that a physician or surgeon may testify as to a death certificate made by him, or as to an autopsy performed by him. Similarly, the Attorney General has held that the information acquired by a local health officer is not privileged when he examines a person in the course of his statutory duties as such officer.

In a recent decision the court has held that a nurse could testify, although the doctor could not, as to a record made by her at a patient's admission and during his treatment, in spite of the fact that the record was used by the doctor in treating the patient, because the statute specifically names only physicians and surgeons. For this same reason, testimony of an interne attendent or roentgen ray operator, or the roentgenogram made by him, is not privileged.

The privilege of the statute may be waived by the patient himself, or by his personal representatives or by beneficiaries of an insurance policy. Although it might appear from a reading of the statute that waiver by a personal representative is to be permitted only in personal injury cases, nevertheless, the court has very recently held that the personal representative may waive the privilege and introduce the testimony of a decedent's physician as to the health and physical condition of the decedent prior to death in a case involving a tax on gifts made in contemplation of death.

Exceptions from the privilege, of course, are those facts learned by the physician in observation or treatment of a person or patient which he is by statute required to report to the proper authorities. Among these are communicable diseases, including venereal disease; cancer, carcinoma, sarcoma or other malignant growths; and occupational diseases. See the article on this subject on page 92.

Among the more common situations arising today in which the physician is asked to disclose privileged information are those in the preemployment or periodic health examination of employes, and those in which an insurance company seeks information to serve as a basis for writing a policy in favor of the patient or for adjusting a claim made by a patient who may carry health, accident or sickness care coverage. For his own protection, the physician must always obtain the signed authorization of the patient before divulging such privileged communications. Such authorization should also identify the person or organization to which such disclosure may be made, and should specify the information to be disclosed. The physician should not disclose information beyond that permitted by the authorization, for if he should go beyond the limits of the patient's waiver, he may be charged with wilful betrayal of a professional secret. Insofar as the periodic health examination or preemployment examination of employes in industry is concerned, the State Society has perfected a specific form of release which appears on model examination forms, approved by the Industrial Commission. These forms are available through the State Medical Society at the cost of printing.

While it is difficult to express a general principle, a physician who is rendering a bill to poor relief

authorities for professional services rendered relief patients should avoid reporting details beyond those absolutely necessary for reimbursement.

Upon making a premarital examination the physician may find that while the applicant is free from venereal disease, he does have some physical or mental disability or abnormality which would render him unfit for marriage or would make impossible the consummation of a satisfactory marriage relationship. The question then arises as to the liability of the physician upon disclosure of his findings to the other prospective spouse.

This problem is discussed in an article appearing in *The Ohio State Medical Journal* for November, 1941. Believing that the conclusions there drawn are of equal merit in Wisconsin we reprint here the conclusions both as to (1) the liability of the physician to the examiner, and (2) the liability of the physician to the state.

"A physician, disclosing to the other prospective marital partner disabilities or ailments of an examinee that would endanger the other party to the prospective marriage or that it would make it impossible for the parties to enjoy a happy or satisfactory marriage relationship, is subject to no liability to the examinee, either in libel or slander or for disclosing a professional secret within the limitations noted; that is, if he acts in good faith and without malice and makes no further disclosures than is reasonably necessary under the circumstances. Obviously, the problem is simplified if the same physician examines both parties with the definite understanding that findings and observations, if at all material to the prospective relationship, shall be made known to the other party; or if the physician acting with respect to one party only enters into a similar understanding."

"The disclosures under the circumstances here assumed would not constitute the 'wilful betrayal of a professional secret' and would not be the basis for the revocation of the physician's license."

In addition to the privilege statute itself, there has been since July 1, 1939, a rule promulgated by the Supreme Court which has the force of statute and reads as follows:

The court or a presiding judge thereof may, upon due notice and cause shown, in any action brought to recover for personal injuries, order the person claiming damages for such injuries to submit to a physical examination by such physician or physicians as such court or a presiding judge may order and upon such terms as may be just; and may also order such party to give to the other party or any physician named in the order, within a specified time, an inspection of such X-ray photographs as have been taken in the course of the treatment of such party for the injuries for which damages are claimed, and inspection of hospital records and other written evidence concerning the injuries claimed and the treatment thereof; and if compliance with the portion of said order directing inspection be refused, the court may exclude any of said photographs, papers and writings so refused inspection from being produced upon the trial or from being used in evidence by reference or otherwise on behalf of the party so refusing. Sec. 269.57 (2).

This rule is restricted to personal injury cases. That part which deals with a physical examination of the injured party is not inconsistent with the privilege statute because the examination is being made not for treatment but for a purpose independent thereof. As to its effect on introduction of records in a trial, it will be noticed that the order does not compel a party to permit inspection of such records and written evidence, but provides a penalty in case of refusal in that the party refusing may not himself use them or produce them in the trial.

ANTITETANUS CHARGES

During the past year the attention of the Conference Committee on Open Panels has been directed to a minor medical problem which deserves comment and clarification. Insurance representatives on the Conference Committee have mentioned that in some sections of the state physicians are making a separate charge for the *administration* of antitetanus, rather than regarding the actual injection of the serum as a part of first aid treatment given in connection with the injury. While such a duplicate charge for service rendered is not common in the state, it seems appropriate to remind all members of the profession that the accepted practice in a medical service of this kind provides for a first aid charge (including checks as to sensitivity), plus a reasonable additional sum (usually $1) to cover the cost of the serum used.

In this connection we would call attention to the action of the American Hospital Association several years ago in reference to this matter:

"In consideration of the action by the Medical Directors Committee of the National Bureau of Casualty and Surety Underwriters in approving the use of antitetanus serum in first aid treatment at the discretion of the physician, and of advising the representatives of its member companies to that effect, the American Hospital Association, through its Committee on Workmen's Compensation and Liability, agrees to advise all member hospitals and clinics that the administration of such serum is to be considered as a part of the routine first aid procedure where indicated, for which no extra charge is to be made by the hospital or clinic beyond a reasonable reimbursement for the material actually used."

R. M. Kurten, M. D., *Chairman*
Conference Committee on Open Panels

Coroners and Autopsies

A COMPLETE discussion of the powers and duties of the coroner would necessitate covering as well the powers and duties of the sheriff or constable, for in the event that a sheriff or his deputy, for one of several reasons, is prevented from performing the duties of that office, the responsibility becomes that of the coroner. Since only in rare instances does such a situation arise, and since such powers and duties bear little or no relation to matters pertaining to physicians, this discussion is limited to the more familiar and specific powers and duties prescribed by law.

The principal contact of the practicing physician with a coroner is in connection with the performance of autopsies requested by that officer. It should be emphasized that unless the physician has the express consent of the immediate family of a decedent, he subjects himself to the possibility of a lawsuit and the payment of damages by performing an autopsy excepting where directed to do so by a:

1. Subpoena issued by a coroner or his deputy subsequent to the ordering of an inquest.
2. Subpoena issued by a justice of the peace who has been ordered by the district attorney to conduct an inquest in the absence of a coroner.

Ordinarily a coroner, his deputy, or an authorized justice of the peace first contacts a physician to inquire whether he is available to perform an autopsy. The physician thus has notice of the intended autopsy before being served with a subpoena. The prudent course for the physician, unless he has personal knowledge of the steps taken and the summoning of an inquest jury, is to make sufficient preliminary inquiries to satisfy himself that such inquest has been ordered. Where the subpoena comes from a justice of the peace he should also check with the district attorney to make sure that the district attorney requested the justice to act in the capacity of the coroner because of the latter's absence. Only by observing such precaution will the physician protect himself against suit by the family of the decedent. See *Koerber v. Patek*, 123 Wis. 453. For fuller treatment of this liability see article on "Malpractice and Malpractice Suits," on page 49 of this issue. Where the situation contains any element of uncertainty, the physician would do well for his own protection to consult his own attorney.

Section 59.34, of the Wisconsin Statutes, provides in part that the coroner shall take inquest of the dead when required by law, and shall perform all other duties required by law.

The most important duty, of course, is that relating to inquests, the details of which are set forth in chapter 366 of the Wisconsin Statutes. The legislature has deemed it advisable to leave with the coroner a wide range of discretion.

Section 366.01 provides that when, from the circumstances surrounding the death of any person, the district attorney shall have good reason to believe that murder or manslaughter, negligent homicide, excusable or justifiable homicide has been committed, he shall order and require the coroner or his deputy to take "an inquest on the view of the dead body of such person." The statute, however, also gives the coroner, on his own initiative, the power to hold an inquest. The function remains substantially as it has for several centuries. The inquest must be held in the county where the wrongful act or accident occurred regardless of the fact that the resulting death took place in another county.

The coroner's source of information of the death of a person is, of course, varied. Everyone, including a practitioner, owes a duty to report a death to proper authorities when circumstances indicate that a homicide or manslaughter may be involved. A physician, presumably, would be in a better position to draw such conclusions than would a layman; and where the practitioner attends a death involving suspicious circumstances, he would do well to notify the coroner or the sheriff's office.

Inquests

The coroner's first duty, upon being notified of a death, in absence of any request by the District Attorney to hold an inquest, is to determine whether or not in his opinion the facts warrant or require the holding of an inquest. This duty is purely discretionary; the only limitation, presumably, being that which relates to the District Attorney, that is whether there is good reason to believe that murder or manslaughter, negligent homicide, excusable or justifiable homicide has been committed. It is impossible to lay down any rules for use in determining when good reason exists. Whether or not the coroner acts will, of course, depend on a number of facts: the objective circumstances of the case, incidental information available to the coroner, and, not to be overlooked, the coroner's own conception of the duties of his office.

Having concluded that the circumstances warrant or demand the taking of an inquest, the coroner's next step is to issue a so-called precept or order to the sheriff or constable to "summon a jury of six good and lawful men of the county to appear before him at the time and place specified in the precept." The coroner may in his discretion dispense with the summoning of a jury and conduct the inquest himself and render a verdict thereon in the same manner as a coroner's jury would do. (In this connection it is pointed out that the power to hold an inquest is an absolute one and should the body have been buried, the coroner or his deputy can compel such body to be exhumed for the purpose of complying with the provisions of

chapter 366, provided an inquest has been ordered.) The form of the order compelling the summoning of a jury is prescribed by the statutes. No time limitation is provided for setting the date of the inquest, but the desirability of prompt action in inquests is self evident, and it is the coroner's duty to see to it that prompt administration of the laws be accomplished. In addition to the order compelling the attendance of the jurors, the coroner may issue subpoenas of witnesses, included among which might be one or more competent physicians or surgeons, for the purpose of making an examination of the body and testifying as to the result of the same. Thus, in the exercise of his powers and duties the coroner is called upon to perform functions which are in their nature both judicial and medical.

Medical Functions

The most important medical duty is the investigation of deaths in which an element of violence may be suspected. These might include accidental or suicidal deaths, and deaths of persons who have not been attended by a duly licensed practitioner of medicine, when the cause of death appears uncertain. In making an investigation, the first consideration is how far it will be necessary to carry the examination, a matter which requires the exercise of care and good judgment. The coroner's questioning should be careful and searching, but having satisfied himself as to the natural cause of death, he is justified in going no further in his investigation. If, however, the death requires the discovery of facts other than those which may be revealed by questioning and inspection the coroner must be in a position to avail himself of those highly specialized medical services involved in an autopsy.

Quasi-Judicial and Other Duties

Having decided on the necessity for an inquest, the coroner's duty immediately becomes one of both an administrative and a judicial character. In Wisconsin, properly speaking, he is not a judicial officer under the state constitution. 20 Atty. Gen. 323. Nevertheless he has the power to exclude the public from inquests whenever he deems that to be desirable. He does the work of a practicing attorney in bringing out the testimony of witnesses, who are not, as a matter of right, entitled to representation by attorney. The statute provides that the jury is to find not only what caused the death, but who was responsible for it. Because of the informality of the procedure, the coroner is in a position to exercise a great influence over the jury even though the jury's findings are not admissible evidence in a subsequent court trial of an apprehended party. See Groeschner v. John Gund Brewing Co. (1921) 173 Wis. 366, at 370. Nevertheless the coroner can frequently be the primary force in bringing a criminal to justice.

Being in charge of the inquest, the coroner, of course, is not in a position either to perform an autopsy or to testify as to the cause of death. If he is a physician, however, his medical training would aid him substantially in preparing questions to be asked of the medical witnesses called. 1910 Atty. Gen. 578.

In the absence of the holding of an inquest the coroner is in no different position than an individual as far as stating the cause of death is concerned. Section 69.39 of the Wisconsin Statutes, provides, however:

> 69.39 Coroner's certificate. Any coroner whose duty it is to hold an inquest on the body of any deceased person, and to make the certificate of death required for a burial permit, shall state in his certificate the nature of the disease, or the manner of death, and if from external causes or violence whether "probably" accidental, suicidal or homicidal, as determined by the inquest; and shall, in either case, furnish such information as may be required by the state registrar to classify the death.

A further duty is imposed upon the coroner by Section 366.19, Wisconsin Statutes, which provides in subsection (2):

> It shall be the duty of the respective coroners of this state, in any case where the body is to be cremated, to view and make a careful personal inquiry into the cause and manner of death, and conduct an autopsy or order the conducting of an autopsy, if in their opinion it is necessary to determine the cause and manner of death, and thereupon certify that no further examination or judicial inquiry concerning the same is necessary, if so satisfied, otherwise, or in the event of doubt to proceed as otherwise provided by law.

This article does not even purport to treat the situation in which the physician performs an autopsy at the request or with the consent of the decedent's immediate family. In such cases no other authorization is required from the coroner or any other public officer. See "Malpractice and Malpractice Suits," page 49.

NEGLIGENT HOMICIDE

"Negligent homicide" is the designation given to a new statutory offense created by the 1941 Legislature. Contained in section 340.271 of the Wisconsin Statutes, the new law provides that any "person who by operation of any vehicle while under the influence of alcoholic beverages or narcotic drugs" or who "by the operation of any vehicle at an excessive rate of speed, or in a careless, reckless or negligent manner, constituting or amounting to a high degree of negligence, but not wilfully or wantonly," shall cause the death of another, shall be deemed guilty of negligent homicide. If guilty of the offense under the first condition stated above, a penalty up to five years' imprisonment, or a fine up to $2,500, or both, may be imposed, while under the last condition, the penalty is up to one year's imprisonment, or a fine up to $1,000, or both.

Narcotic Laws

General Statutes and Regulations

THE December, 1941, Blue Book issue of *The Wisconsin Medical Journal* contained an article written by the U. S. Commissioner of Narcotics, H. J. Anslinger, entitled "The Harrison Narcotic Act, and the Practitioner." This study which is not reprinted here is both authoritative and complete and sets forth in detail the provisions of the act and its relation to the practitioner. The Harrison Narcotic Act was technically drafted as a revenue measure, for only through the taxing power can the federal government control or regulate traffic in drugs within the states themselves, but it was primarily intended, as Justice Holmes pointed out in United States v. Jin Fuey Moy, (1916) 241 U. S. 394, to control and regulate the sale and use of narcotics.

The State Law

The federal act, however, because of constitutional limitations on the scope of its operations, was not sufficient. Supplemental state legislation was essential. This need was recognized by the proposal in 1932, by the National Conference of Commissioners on Uniform State Laws, of a "Uniform Narcotic Drugs Act," and since that time, forty-one states, including Wisconsin, have adopted the act; the Wisconsin Law being enacted by chapter 306, in the Laws of 1935 as chapter 161, Wis. Stats. The 1941 Legislature enacted several amendments which are noted below at appropriate places, and which are designed either to make the state act conform with the federal, or to strengthen administration of the act.

The state act was intended to facilitate the regulation, control, and enforcement, with particular emphasis on enforcement, of the use of narcotics in conformity with the aims and purposes of the federal act. In drafting the state law, effort was made to avoid any duplicate effort, either on the part of the enforcement officers or the persons subjected to the act. The state law makes specific reference to the federal act and provides that a compliance with the federal law shall constitute a compliance with corresponding sections of the state law. The procedure to be followed by practitioners and others subject to the law is adequately set forth in the article by Commissioner Anslinger, which was printed in the December, 1941, issue on page 1240. From it the practitioner may obtain the general procedure required of him. Some statutory requirements and penalties relating to the physician's professional use of narcotics and marijuana are summarized for the physician's convenience at the end of this article. There are certain additional factors which merit consideration by the practitioner, some of which arose subsequent to the passage of the Wisconsin law, and which, while not specifically falling under the provisions of the federal Harrison Narcotic Act, are related to the subject in a general way.

Use of Narcotics and the Practitioner

It must be remembered, first of all, that the practitioner can use narcotics only in connection with patients upon whom he is in attendance in the regular course of his professional practice. Except for the provisions of Sec. 161.27, Wisconsin Stats., forbidding the possession and use of opium pipes and Sec. 161.275, as enacted by chapter 49 of the Laws of 1939, outlawing smoking preparations of hemp or loco weed and the use of marijuana in a form suitable for smoking or beverage purposes, neither the state nor federal act places any limitation upon the quantity that may be used, the time during which it may be continued, or the form in which it may be administered.

The courts have, however, definitely held that the administering, dispensing and prescribing of drugs for the sole purpose of satisfying the craving of an addict is not within the limits of professional practice as contemplated by the act. In the use of such drugs the practitioner must always act in good faith. Because of this construction of the act by the courts and the similar position taken by the federal authorities the practitioner should take care to avoid any suspicion of noncompliance, not so much because of possible conviction but because of the trouble, expense and adverse publicity which might result should an innocent practitioner be charged with violation of the act.

Hitherto, certain small quantities of narcotics were exempt from the provisions of the state act where prescribed, dispensed, or sold at retail. A 1941 amendment limits the exemption to preparations which do not contain an excess of 1 grain of codeine or any of its salts in one fluid or avoirdupois ounce. The preparation containing codeine must also have medical value other than that possessed by the narcotic alone. All other preparations are now in the prescription class. In consideration of the narcotic law's application, the practitioner should keep in mind the following three phases of the problem: administration, dispensation, and prescription.

1. *Narcotics Administered by Practitioners.*—It is in this branch of the use of narcotics that the practitioner is given the greatest freedom. Under the federal law, he is not compelled to keep a record of the drugs administered either by himself or by his duly authorized assistant, intern or nurse. The state law, however, does require practitioners to

maintain a record of any narcotic drugs administered except—

Narcotic drugs administered, dispensed or professionally used in the treatment of any one patient, where the amount administered, dispensed or professionally used for that purpose does not exceed in any forty-eight consecutive hours, (a) four grains of opium, or (b) one-half of a grain of morphine or of any of its salts, or (c) two grains of codeine, or of any of its salts, or (d) one-fourth of a grain of heroin or of any of its salts, or (e) a quantity of any other narcotic drug or any combination of narcotic drugs that does not exceed in pharmacologic potency any one of the drugs named above in the quantity stated.

2. *Narcotics Dispensed by Practitioner.*—Under both acts, the practitioner is required to keep a record of all narcotic drugs dispensed by him, such record showing the amount, date dispensed, name and address of the patient; this record must be kept for two years. One record will suffice for both federal and state requirements. When the practitioner's office is accessible to the patient, the dispensing of narcotics should be avoided as much as possible; certainly no more should be placed in the hands of patients than is necessary to provide until the next visit.

Attention is called to a special rule applicable to physicians dispensing exempt narcotic preparations, such as paregoric. The rule is expressed both in the federal act and in the treasury regulations and provides that a dispensing physician, among others, must keep a record of all sales, exchanges, gifts or other disposition of such exempt preparations. The record of disposition must be made at time of delivery and must show the name and address of the patient, the name and quantity of the preparation and date of delivery. A 1942 amendment to the regulations holds this rule to be an independent requirement of law, binding on all physicians and others who dispense exempt preparations. Any violation of the rule is subject to the criminal provisions of the Harrison Narcotic Act.

3. *Prescribing by Practitioner.*—The laws do not compel the practitioner to keep records of the prescriptions issued, but the physician's case records should be complete and in detail. The practitioner should bear in mind that the best professional opinion seems to recognize the fact that an attempt to cure an addict outside the walls of a hospital or other institution is almost certainly doomed to failure, and that an attempt to cure under such circumstances may furnish grounds for suspicion of violation. Both the federal and state laws contain specific reference to drug addicts, and it is only in exceptional cases, such as those of aged and infirm persons, that a practitioner is justified in furnishing an addict with the means of obtaining a supply of drugs, and then only in the course of the physician's "professional practice."

The physician must never prescribe, dispense or administer narcotics to a "transient addict" merely to satisfy such addict's narcotic requirements. If the physician determines *after* a physical examination that the addict is in need of medical treatment and that as a part of such treatment he should have narcotics in an amount which is reasonable for the particular patient, the prescription, dispensing or administration of narcotics under such circumstances is within the law.

Marijuana

It should be noted that the Harrison Narcotic Act does not regulate the production, manufacture, sale or use of marijuana. Instead, this is made the subject of separate federal regulatory legislation which is in terms almost identical with that on narcotics. A physician desiring to administer, dispense, prescribe or give away marijuana must, in order to comply with the federal act, first be registered for such purpose separately from his narcotics registration and must keep records similar to but independent of those showing disposition made of narcotics. The Wisconsin act includes cannabis, of which marijuana is a variety, in the definition of narcotic drugs, thereby making the act uniformly applicable to coca leaves, opium and marijuana.

The definition of "cannabis" was broadened by a 1941 amendment so that the state act is now identical in that respect with the Federal Marijuana Act of 1937. The term "cannabis" under the statute now includes all parts of the plant Cannabis sativa L., whether growing or not, the seeds thereof, the resin extracted from any part of the plant, and every compound, manufacture, salt, derivative, mixture or preparation of such plant, its seeds, or resin. There is exempted from the definition only the matured stalks of the plant, the devitalized seed and seed products.

It should be noted that a 1941 amendment now requires that records be kept by the physician of *all cannabis dispensed*, as is already the federal law.

State and Federal Penalties

Violation of the statutes relating to narcotics or marijuana is made a crime, and the severe penalties imposed reflect a public policy which demands that the use of these drugs be limited to legitimate medicinal purposes. For violation of the federal narcotic act the statute provides penalties varying from a fine up to $2,000 and imprisonment up to five years, or both, to a fine up to $10,000 and imprisonment up to twenty years, or both, and for the imposition of more than one fine, or imprisonment, or both, for a given violation. The state penalties are not so heavy, being limited on the first offense to a maximum fine of $200, or a maximum jail sentence of three months, or both, and for any subsequent offense to a fine of $100 to $1,000, or imprisonment in the state prison up to five years, or both. The state statutes also provide that there shall be no prose-

cution under the state narcotic law where a person has been acquitted or convicted under the federal law for the same act or omission.

The penalty for violation of the federal marijuana law is a fine of $2,000 or imprisonment, up to five years, or both, and for violation of the general marijuana provisions of the state law, the same penalties as those set out above for violation of the narcotics provisions.

Patient "Narcotic Permits"

Neither the state nor federal laws confer on *any* narcotic or other governmental enforcing agent *any* authority to grant any kind of permit to any individual purporting to entitle him to have narcotics dispensed or prescribed for his personal use. The government, both state and federal, leaves this entirely up to the professional judgment and good faith of the medical profession. No such purported "permit" presented by a patient has any legal validity whatever, and, therefore, affords the physician no protection.

Death of Registered Physician

Notice of the death of a physician registered under the federal Narcotics or Marijuana Acts should be given promptly to the Collector of Internal Revenue, Federal Building, Milwaukee, by his family, administrator or executor. The collector will forward instructions as to disposition to be made of narcotics or marijuana on hand. If the family, administrator, or executor of the deceased physician's estate so desires, authority can be obtained from the Collector of Internal Revenue to sell the stock of narcotics left by the physician. Such stock can be sold, for example, to another physician who is registered under the Narcotics or Marijuana Acts. It must be noted, however, that narcotics can be sold only to a physician registered under the Narcotics Act and that marijuana can be sold only to a physician registered under the Marijuana Act. If the family, or the personal representative, of the deceased physician prefers not to dispose of the stock by sale to another registered physician, unbroken packages can be returned to the original source of purchase, but broken packages of narcotics must be forwarded by prepaid express to the narcotics district supervisor, who at present is Mr. J. J. Biggins, 817 New Post Office Building, Chicago, Illinois.

Military Service of Registered Physician

In the case of a physician who enters military service and closes his office during such period, it is proper for him to retain his stock of narcotics and marijuana so long as he is careful to place it in a safe or some other place which will put it out of ordinary reach.

A medical officer in the armed forces who is authorized by the surgeon general of the Army or Navy to obtain necessary drugs and preparations for official use in the service is exempt from federal requirements of annual registration and the payment of the annual tax. A physician entering the armed forces who is certain that he will engage in no private practice requiring the use of narcotics while in service may advise the Collector of Internal Revenue at Milwaukee of this fact, and relinquish his narcotic registration number, dispose of his stock of narcotics as directed or permitted and cease to register or pay the annual tax until his return to civilian practice. However, a military, naval or contract physician who engages in any private practice which calls for the use of narcotics must retain his registration number, renew it annually, and pay the annual tax.

If the physician going into service has employed another physician to take over his practice, it will be necessary for such a substitute physician himself to be registered before he can use any of the stock on hand. One purchasing the practice of a physician going into military service must likewise be registered in order to purchase or use his narcotic or marijuana stock. The regular order form prescribed by the government must be used for this purpose.

Important Federal Requirements and Date Lines

1. A physician desirous of using narcotics or marijuana in the course of his professional practice, who is registering for the first time, may do so at any time of the year. He should first request a narcotics application form from the office of the Collector of Internal Revenue, Federal Building, Milwaukee. This should be carefully filled out, witnessed or notarized, and returned to the collector, together with a special annual tax of $1.

2. Physicians who have registered before under the narcotics law will receive reregistration Form 678 from the Collector of Internal Revenue in May of each year. This should be carefully prepared and returned along with the annual tax of $1 *on or before July 1 of each year.* A physician who does not receive a reregistration form on or before July 1 is under duty to request one from the collector.

3. There must accompany the registration application and annual tax a sworn inventory on Form 713 showing narcotic drugs on hand in the physician's office. This, like the reregistration and tax, must be filed on or before July 1 of each year.

4. A physician may *not* order narcotics on his own prescription blank, but must use the official duplicate order book prescribed by the Collector of Internal Revenue, which may be purchased from the Collector's office, Federal Building, Milwaukee, for 10 cents. The order book may be requested on Form 679.

5. Unless a physician has registered, paid his tax, and filed an inventory, on or before July 1 of each year, it is a violation of law for him to administer, dispense, prescribe, give away or transport nar-

cotics or marijuana until he has first complied with the law in all above respects. In the case of narcotics it is a violation of law for the physician even to be in possession of such drugs under these circumstances.

6. Fines are imposed on a physician who either negligently or wilfully fails to keep or display in a prominent place in his office the stamps denoting payment of the special annual tax on the use of narcotics or marijuana for professional purposes.

7. A physician who maintains two or more offices in different locations must register each office separately and pay the special annual tax of $1 for each.

8. The physician should report stolen narcotics at once to the narcotics district supervisor who at the present time is Mr. J. J. Biggins, 817 New Post Office Building, Chicago, Illinois. Accompanying the report should be an affidavit which sets out the circumstances of the theft so far as they are known to the physician, the quantity taken, and the further fact that prior to making the affidavit local police authorities have been notified of such theft. A copy of such affidavit is to be retained by the physician and filed with his other narcotic records so as to be available at any time for inspection.

9. The following should be reported promptly to the Collector of Internal Revenue, Federal Building, Milwaukee:

(a) Removal of office. This is merely a matter of reregistration and does not require a new permit or payment of an additional tax.

(b) Discontinuance. A registered physician desirous of discontinuing either his practice or the administration, prescription or dispensing of narcotics or marijuana should notify the collector of his intention not later than June 30, the close of the tax year. He will receive special instructions as to disposing of his stock, etc.

(c) Death. See "Death of Registered Physician," page 83.

10. The physician should remember that if he desires to use marijuana in the course of his professional practice he must register, pay a tax and furnish an inventory on marijuana independently of those same requirements for narcotics, the latter being restricted by statutory definition to opium or coca leaves, or any compound or derivative thereof.

11. No registration is required under the Wisconsin act by physicians desirous of making professional use of coca leaves, opium or cannabis.

12. Some physicians have recently purchased large stocks of narcotics, apparently for the twofold reason that they feared a shortage in available supply and a rise in prices. From information made available by the United States Commissioner of Narcotics, Hon. H. J. Anslinger, whose article was printed in the December, 1941, issue on page 1240, it appears that both premises are false, at least for the immediate future. The commissioner holds that a physician who purchases a stock of narcotics beyond his reasonable needs for the ensuing ninety days is making excessive purchases. The physician who has an excessive narcotic stock on hand runs the risk of theft, ties up his money, and also runs the risk of a special investigation by a narcotics agent.

The Wisconsin office for the Federal Bureau of Narcotics is located in the Federal Building, Madison, and any communications or inquiries should be sent to the narcotics agent at the above address.

IDENTIFICATION BY BLOOD TEST

Whenever relevant to the prosecution by the mother, or defense by the alleged father, in an illegitimacy action, the trial court may order the mother, child and alleged father to submit to one or more blood tests to determine whether the defendant can be excluded as the father of the child. The results of the test are admissible only to prove that the defendant is not the father; the results of a test which show only that the defendant might be the father are not admissible. Such tests are conducted by a physician or physicians, licensed to practice medicine and surgery, or by another duly qualified person or persons, not to exceed three, who are appointed by the court and paid by the county. Sec. 166.105, statutes.

Whenever relevant in a civil action to determine the parentage or identity of any child, person or corpse, the court may direct any person or persons involved to submit to one or more blood tests under restrictions and directions deemed proper by the court. Only where definite exclusion of the person involved in the controversy is established by the test are its results receivable in evidence. Sec. 325.23, statutes.

Sterilization

IN 1932, and again in 1938, opinions from the office of the attorney general of Wisconsin indicated the belief of that office that sterilization operations, except in the course of strictly therapeutic surgery, would be held illegal by the Wisconsin courts. Because of the importance of those opinions, they are printed here in summary.

1932 Opinion

The first of the two opinions was rendered by Deputy Attorney General Fred M. Wylie in 1932 in 21 Atty. Gen. 940:

"You ask opinion upon the following:

We have advised the county judge and the county children's welfare board that section 46.12 does not prohibit a sane person over twenty-one years of age from being sterilized, if he or she so wishes. We find no other section in the statute pertaining to sterilization. Please advise if our opinion was correct. Is a doctor protected in sterilizing persons who appear there voluntarily?

Is it possible for a county to pay for sterilizing indigents who are now receiving county aid and who voluntarily offer themselves for sterilization?

"Offhand, it is likely to appear that a competent adult may legally consent to be sterilized, not merely as a curative or preventive therapeutic, but solely to prevent procreation. I do not say that he or she may not, but there is sufficient contra indication in the law and in the disclosed attitude of some judges, to cause one to advise physicians that it is unwise for them to perform such an operation for sterilization purposes alone.

"Sterilization has not been received by the courts with any open-armed welcome. Against the opposition of those of the public and on the courts who consider such interference with nature to be immoral or sinful, legislatures have so far made no great strides, and a great deal of what has gotten past the opposition in legislatures has succumbed in courts.

"Even if we assume that the scientific and sociological view should prevail, nevertheless the law follows science, in some fields by perhaps a generation, for the law can reflect the advances of sciences only when they have been accepted by the people generally. Science may have a duty to educate the law, but it has no duty to defy it, nor to take a serious chance with it. The consequences to a physician from the performance of an operation of this kind, should the courts hold it illegal, could be serious. Until the law is settled, it is not prudent for a physician to perform a sterilizing operation except within the ancient field of surgery, viz., when it is a therapeutic measure.

"And if the poor relief officials should, as you suggest in your letter, become parties to the performance of such an operation, they, as well as the physician, would be liable to the penalties of the criminal law in case the courts should follow the letter of the old common law and hold that change in the application thereof can be only by legislative action.

"It is not my intention in this opinion to take any position upon the religious and sociological phase of the question. It is my personal and official opinion, however, that the legal question is better to be settled in the legislature than in the courts with some well-intentioned public official or physician as the potential victim."

1938 Opinion

The second of the two opinions was written by Assistant Attorney General Warren H. Resh in 1938, and is printed in 27 Atty. Gen. 416.

We quote the following excerpts:

"You ask whether a vasectomy 'can be performed safely' where the patient is willing to consent in writing and where it is the opinion of several examining physicians that the operation would benefit the patient's health. The man is not confined in an institution as a criminal, insane, feeble-minded or epileptic person and therefore sec. 46.12, Stats., relating to sterilization does not apply. No doubt you have in mind the mayhem statute, sec. 340.35, and the question is whether this statute would forbid sterilization in the present circumstances.

"The only case involving voluntary sterilization which has come to our attention is Christensen v. Thornby, (Minn.) 255 N. W. 620, a case notable in that the plaintiff sued on a theory of breach of warranty in that the operation did not have the desired effect, and he sought to measure his damages by the expense of a subsequent and unexpected childbirth. The court held that the contract was not void as against public policy, since it was thought to be necessary to save the life of the plaintiff's wife.

"In this regard necessity to save life and necessity to preserve health should stand on an equal footing, because of the difficulty of telling in some cases where one stops and the other begins. It is only because justified by the necessity to preserve health that a dentist who pulls an ailing incisor does not commit mayhem under the broad terms of the statute. Likewise with the physician.

"We conclude that vasectomy in the instant case may be excusable by reason of necessity to preserve health. For a more complete discussion of the subject we refer you to Miller and Dean's article in 16 Am. Bar Ass'n Journal 158 (1930). See also XXI Op. Atty. Gen. 940."

Tax and Permit Provisions of State Liquor Laws

UNDER the laws of Wisconsin, "intoxicating liquors" are defined as: ". . . all ardent, spirituous, distilled, or vinous liquors, liquids, or compounds, whether medicated, proprietary, patented, or not, and by whatever name called, containing one-half of one per cent or more of alcohol by volume, which are fit for use for beverage purposes . . ." Sec. 176.01.

Section 139.26 imposes a tax on intoxicating liquors but exempts those used by hospitals for medicinal or hospital purposes. Sec. 139.26 (1) and (1a). Section 176.401, Wisconsin Statutes, provides tax exemption for alcohol "intended for use and used in the manufacture and sale" of medicinal, pharmaceutical and antiseptic preparations when unfit for beverage purposes. There is no tax exemption for intoxicating liquors prescribed for medicinal purposes by a physician other than as those may be purely medicinal and not fit for beverage purposes. A substantial penalty is provided if patented, proprietary, medicinal, pharmaceutical, antiseptic, or toilet preparations are sold for intoxicating beverage purposes. Sec. 176.401 (2).

Those who deal in intoxicating liquors are generally required to secure a state license, but the physician (and hospital) is exempt from this requirement where his use thereof is "in the bona fide treatment of the sick or in using or prescribing such alcohol for such bona fide treatment." However, the physician must secure from the state treasurer a permit to receive shipments of alcohol for medicinal purposes. This permit will be issued without charge to any person who proves to the state treasurer that he uses such alcohol for medicinal purposes. Sec. 176.04 (3), also 176.404 (1), Wisconsin Statutes.

Because of the importance of the provisions in the laws relative to physicians and surgeons prescribing liquor in unnecessary amounts or under unnecessary circumstances the following provisions contained in Section 176.19 are printed here in full:

(1) It shall be unlawful for any physician or surgeon to prescribe intoxicating liquors for any person when unnecessary for the health of such person, or to prescribe a greater quantity of such liquor than proper for the ailment or disease of such person, with intent to evade or assist in evading any of the provisions of this chapter. Nothing in this chapter shall be construed as prohibiting any hospital or one licensed to practice medicine or surgery from having and using alcohol, in any form, in the bona fide treatment of the sick, nor as requiring either to have a permit or license to have, use, or prescribe the same for such bona fide treatment.

(2) Any physician or surgeon violating any of the provisions of this section shall be punished by a fine of not less than two hundred and fifty dollars nor more than one thousand dollars or by imprisonment in the county jail or house of correction not more than six months; and conviction for a second offense within any one year shall be ground for revocation of such defendant's license to practice medicine and surgery in this state.

Medical Aspects of Marriage Laws

THE Wisconsin Statutes impose a number of conditions which must be fulfilled before a marriage can be recognized as valid in this state. Some of these are quite unrelated to medicine, but others have medical aspects. Only those which are peculiarly within the province of the practicing physician will be indicated below.

Premarital Examinations

1. *Freedom of male from venereal disease.*—The law requires all male applicants for a license to marry to obtain and file with the county clerk a certificate to the effect that the physician has thoroughly examined him and believes him to be free from any venereal disease, the examination to have been made within fifteen days of the marriage application.

The certificate provided by statute is in the following form:

I, _____ (name of physician), being a physician, legally licensed to practice in the state of _____, my credentials being filed in the office of _____ in the city of _____county of_____ State of _____, do certify that I have this _____day of _____19____ made a thorough examination of _____ (name of person), and believe him to be free from all venereal diseases.

_____(Signature of physician)

The physician must be one duly licensed to practice in Wisconsin or in the state where the male applicant resides. The fee for such examination and certificate, by statute, shall not exceed $2. Where the applicant is an indigent the examination is made without charge, on request, by the county or asylum physician. If, in the opinion of the examining physician, a microscopic examination for gonococci is required, it shall be made by the State Laboratory of Hygiene free of charge at the request of the examining physician.

2. *Negative Wassermann tests for both applicants.*—*Both* parties to a proposed marriage shall, within fifteen days of their application, be given a Wassermann or other standard blood test for syphilis. The test must be performed in a laboratory approved by the State Board of Health as competent to make such examination, or at the Wisconsin Psychiatric Institute free of charge, and if the results are negative a certificate in the following form is given the applicant:

I, _____(name of physician), being a physician, legally licensed to practice medicine and surgery in the state of _____ my credentials being filed in the office of _____ in the city of _____county of _____ state of _____ do certify that_____ (name of person) was given the Wassermann or other standard blood test for syphilis at _____ _____(name of laboratory) from blood taken by _____ on the _____ day of _____ 19____ and that the result of such test was negative.

_____
(Signature of physician making laboratory test)

Note: There is provision for nonresidents securing their blood tests in their own state requiring the submission of the original certificate from the laboratory together with a statement from the State Health Officer of the state (or his representative) to the effect that he believes the laboratory competent to make the test.

A new section, Section 245.10 (6) was created by the 1945 Legislature providing that when an examination as to existence or non-existence of a venereal disease is made of a person serving in the military forces of the United States, the examination and certificate may be made by any physician serving as such in the military forces and the test may be made in any United States military laboratory and the certificate of negative findings prescribed by Section 245.10 (5) may be subscribed by any physician serving as such in the military forces. In both cases the subscribing physician shall give his military rank and station.

The State Board of Health, at its regular bimonthly meeting on November 13, 1943, approved the following rules governing the approval of laboratories for doing serological tests as required by the marriage license law:

1. For approval a laboratory for this purpose must be under the direction of a licensed doctor of medicine, unless otherwise provided by special action of the State Board of Health, who is a recognized pathologist and who devotes at least half of his time to the supervision of such laboratory.

2. Each laboratory must make application to the State Board of Health for approval under this provision.

3. If there is a change in the directorship of the laboratory it must be reported to the State Board of Health and the laboratory must reapply for approval.

It is of interest to note that the State Board of Health has ruled that it will accept tests done in the laboratories of the armed services and premarital statements of medical officers of such services as a requirement for marriage.

3. *Physician penalties.*—The statutes provide that any physician who knowingly and wilfully makes any false statement in either of the certificates set out above shall be punished by a fine up to $100 or by imprisonment up to six months.

4. *"Wassermann-fast" cases.*—Section 245.11(4) provides:

In the case of an individual whose laboratory test for syphilis results in a positive finding, when in the opinion of his attending physician the individual no longer has syphilis in an infective or communicable stage, the state board of health may review the findings and clinical evidence through a deputy state health officer and thereafter the state health officer is empowered to grant a certificate to the county clerk that the individual is not in the infective or communicable stage of syphilis if such be his best judgment.

The effect of the above subsection is to make it possible for a syphilitic applicant to marry so long as his disease is not in an infective stage. Under a rule of the State Board of Health, made in September, 1939, a case of syphilis is ordinarily not considered "Wassermann-fast," or noncommunicable, until there have been at least twenty arsenical treatments and a similar number of treatments with heavy metals, all at proper intervals. Under this subsection, however, the rule is not applied arbitrarily but is relaxed as the merits of each individual case may warrant.

To avoid unnecessary correspondence, and in order to enable the examining physician to supply lacking information, forms have been prepared and are available from the offices of the State Board of Health on which physicians requesting special consideration of noncommunicable cases may make application to the state health officer. In accordance with provisions of the above section when this form is submitted by the physician, including his statement that in his opinion the individual no longer has syphilis in an infective or communicable stage, and if, after review of the files and clinical evidence by a deputy state health officer, it is the best judgment of the state health officer that the individual is not in an infective or communicable stage, he issues the required certificate which is sent directly to the county clerk.

The Attorney General of Wisconsin has recently ruled that only applicants who have submitted to a blood test for syphilis within fifteen days of applying for a marriage license, which test resulted positively, may avail themselves of the special procedure above provided. See 29 Atty. Gen. 354.

Marriage Laws

While the physician is not professionally concerned with the marriage laws of the state except insofar as he may be directed or authorized to make antenuptial physical examinations, nevertheless he is not infrequently asked for general advice in his position as family counselor. In Wisconsin, civil, not ecclesiastical, law governs the marriage contract. It is nevertheless complicated and to a considerable extent an unadjudicated field of contract law.

Under the Wisconsin law every male person who shall have attained the full age of 18 years and every female who shall have attained the age of 15

years is capable of contracting marriage if otherwise competent. Between the ages of 18–21 years as to the male and 15–18 years as to the female, consent of the parents or guardian, or an order of the county court of the county in which the marriage license application is pending, is necessary.

An attempted marriage on the part of one who is insane, imbecilic, feeble-minded, epileptic or idiotic is absolutely null and void in this state, cannot be ratified, and may be challenged by a party to the marriage or by one validly interested therein and either during or after the lives of either or both parties to the marriage. These are apparently the only marriages which are absolutely null and void from the beginning.

Where parties under age have failed to secure the consent of the parents, but have been married in good faith, their marriage is not void but merely voidable upon positive action by one of the parties or his guardian. Where the parties marry while under the lawful ages above set out, the marriage may be annulled unless the parties affirm the contract after reaching 15 years if it was the female who was not of proper age, or 18 years in the case of the male.

If a resident, who is disabled or prohibited by Wisconsin laws from marrying here, does so, such marriage is null and void for all purposes in this state. This has reference only to attempted marriage by the insane, imbecilic, feeble-minded, epileptic or idiotic, or those who have been divorced for less than one year. Other marriages, even though contracted in another state in order to avoid Wisconsin regulatory laws such as those relating to antenuptial physical examinations, are not invalid in Wisconsin. Where the ceremony is performed outside of Wisconsin and the parties return to it to reside, they are required under the provisions of section 69.48, Wis. Stats., to fill out and file a blank marriage certificate with the local registrar of vital statistics within ten days after their return.

As previously indicated, the marriage laws of this state are complicated and cannot be applied by general rule to any given situation. The physician should have a general awareness of them in the sense that all matters concerning the public welfare and particularly the field of public health come within his professional concern.

Care of the Illegitimate Child*

SINCE the passage of the Children's Code, the state, first through the Board of Control and more recently through the Board of Public Welfare, has been responsible for working with the children born out of wedlock.

The Wisconsin Statutes provide in Section 46.03 (11):

> "The Board shall promote the enforcement of all laws for the protection of mentally defective, illegitimate, dependent, neglected, and delinquent children except laws whose administration is expressly vested in some other State Department. To this end it shall cooperate with Juvenile Courts and all licensed Child Welfare agencies and institutions of a public or private character, and shall take the initiative in all matters involving the interest of such children where adequate provision therefor has not already been made or is not likely to be made."

Section 46.03 (12) further provides that

> "When notified of the birth or expected birth of an illegitimate child the Board shall through the advice and assistance of the mother, or, if necessary, independently of the mother, see to it that the interests of such child are safeguarded, that appropriate steps are taken to attempt to establish the paternity and that there is secured for him the nearest possible approximation to the care, support and education that he would be entitled to if born in lawful wedlock."

The Department of Public Welfare delegates its responsibilities in this field to the Division of Child Welfare. The reports of the unmarried mother come to this Division through many sources:—The mother herself; relatives; physicians; hospitals; attorneys; pastors; schools; private agencies; or friends. Some of the mothers need very little help, as they have thought out carefully their plans for confinement and care of their child; others are completely bewildered. For the unmarried mother who plans to keep her child with her in her own home, ordinarily plans are worked out for her confinement in her own community. She may need advice as to how to proceed with action against the alleged father, so as to insure, whenever possible, legal adjudication of paternity, as well as financial contribution from the alleged father toward the support of the child.

There is a limited Field Staff in the Division of Child Welfare, and cases coming to the attention of the Division are therefore often assigned to licensed Child Welfare Agencies and County Children's Workers, depending upon the age, religion and legal settlement of the mother.

The licensed agencies giving service in this type of case are:

The Children's Service Society of Wisconsin, 734 North Jefferson Street, Milwaukee 2.

* Prepared for The Journal by Miss Dorothy Waite, Division of Child Welfare, State Department of Public Welfare, State Capitol, Madison.

The Lutheran Welfare Society, 3005 West Kilbourn Avenue, Milwaukee 8.

Lutheran Children's Friend Society, 8138 Harwood Avenue, Wauwatosa.

Green Bay Diocese Apostolate (Catholic), 131 South Madison Street, Green Bay.

Catholic Child Welfare Bureau, 3222 South Avenue, La Crosse.

Catholic Social Welfare Bureau, 625 North Milwaukee Street, Milwaukee 2.

Jewish Social Service Association, 2218 North Third Street, Milwaukee.

Catholic Welfare Agency, 1200 Fifteenth Avenue, East Superior.

When the unmarried mother wishes to release her child for adoptive placement the situation is referred at an early date to one of the licensed Child Placing Agencies in the state, who are in a position to help her not only in making plans for her confinement, but also in making plans for her child's future. Many of the agencies listed maintain District Offices throughout the state, so that if a physician should make a referral to the main office, that office in turn will inform the unmarried mother of the District Office located closest to her home.

Maternity Homes

Oftentimes it is necessary to assist the unmarried mother in leaving her home community so her condition need not be revealed to other members of her family or friends. Sometimes she has funds sufficient so that she can pay for her own care in a private boarding home in a community far enough removed from her home so that some secrecy can be assured, and arrangements are made for her care by a private physician of her own choice, and confinement in a private hospital. Other mothers choose to enter Maternity Homes, and there are several Homes in the state offering this type of care. These Homes are:

Salvation Army Martha Washington Home, 6306 Cedar Street, Wauwatosa.

Misericordia Hospital (Catholic), 2224 West Juneau Street, Milwaukee 8.

St. Ann's Maternity Annex (Catholic), 1020 Market Street, La Crosse.

St. Mary's Mothers' and Infants' Home (Catholic), 403 South Webster Avenue, Green Bay.

Summit Hospital, Oconomowoc.

Admission to these hospitals may be made either by writing the hospital directly, through contacting the Division of Child Welfare, or through one of the licensed Child Placing agencies. All Maternity Homes require a negative smear, Wasserman, and throat culture before the patient is admitted. Fees for care at the hospitals vary between $50 and $100. This includes the girl's prenatal care, confinement, and care after the birth of the child until such time as her own plans are completed and she is ready to leave the hospital. At Summit Hospital the girls may remain long enough to work out their entire bill. At the Maternity Homes the girls are given some duties which contribute to the cost of the care which they receive. Formerly it was necessary for the unmarried mother to remain with her child in certain Maternity Homes for a definite period of time after the child's birth. This, however, is no longer true, and the mother may leave the Maternity Home any time after the birth of the child when the attending physician feels that she is physically able to leave and there is a satisfactory plan made for her child.

Plans For the Child

Upon the mother's discharge from the hospital there are several plans which she may consider for the care of her child, and the decision as to the final plan must be her own. (1) She may take the child with her to her own home or the home of relatives. (2) The child may be placed in an approved foster home under the supervision of either a licensed Child Placing Agency or a County Children's Worker, pending the time when the mother definitely decides as to whether she wishes eventually to take the child into her own home, whether she plans to marry the alleged father, or whether she wishes to release her child permanently for adoptive placement. The licensed Child Welfare agencies listed earlier are licensed to place children in adoptive homes. The advantage of working through a licensed agency, of course, is that neither the mother nor the prospective adoptive parents have any contact with each other. The mother is given time to fully make up her mind whether she wishes to keep her child or whether she wishes to definitely release it. Although this method of placement takes longer than it would if more hasty placements were made, it has been proven that in the long run the child is happier, the unmarried mother has been given time to carefully think out the plan so that she will have no regrets, and the adoptive parents are assured that a child will be placed in their home who will become a very real member of their family group.

The laws regulating the placement of children place definite restrictions on any person or agency not licensed to perform this function. If an unmarried mother comes to a physician and expresses her desire to release her child for adoption, we would suggest that the physician immediately refer her to the Division of Child Welfare or to one of the licensed Child Welfare agencies mentioned earlier in order to avoid violating this law.

The Statute reads as follows:

> "48.37 **Licenses; Records; Reports.** (1) No person other than the parent or legal guardian, and no firm, association or corporation, and no private institution shall place, assist, or arrange

for the placement of any child in the control and care of any person, with or without contract or agreement, or place such child for adoption, other than a licensed Child Welfare Agency."

"48.40 **Violation.** (1) Whenever the State Board of Control shall be advised or shall have reason to believe that any person, firm, corporation, association or private institution, is conducting or acting as a Child Welfare Agency in this state without being licensed as in this chapter provided, or is in any way, directly or indirectly, offering to place any child or holding himself or itself out as being able to place or dispose of children in any manner, it shall make an investigation to ascertain the facts. If it finds that such person, firm, corporation, association or private institution is so acting without a license, it may either issue a license upon application therefor, or may cause a prosecution to be instituted under the provisions of Section 48.41.

"48.41 **Penalties.** (1) Any person who shall act as a Child Welfare Agency without a license as provided in this chapter or who shall violate any of the provisions of the Statutes relating to the organization, conduct and operations of Child Welfare agencies, or who in any way, directly or indirectly, offers to place or dispose of any child or hold himself out as being able to place or dispose of children in any manner whatsoever, shall upon conviction thereof be punished by a fine of not less than ten nor more than five hundred dollars or by imprisonment in the County Jail for not more than one year, and said term of imprisonment in case of an association or corporation may be imposed upon its officers who participated in said violation."

If there are any questions arising regarding particular cases we would like to suggest that the physicians get in touch with the Division of Child Welfare at 315 South Carroll Street, Madison, Wisconsin.

RECENT ATTORNEY GENERAL OPINION ON COMMITMENT EXAMINATION FEES OF INTEREST TO WISCONSIN M. D.s

Physicians concerned with medical examinations made in connection with the commitment of persons alleged to be insane or senile will be interested in a recent attorney-general's opinion on the subject of medical fees, rendered at the request of Norris E. Maloney, district attorney of Dane County.

In seeking a ruling on the subjects covered by the opinion rendered Mr. Maloney raised two issues:

"(1) When and if the County Board acts to establish the medical fee at a sum greater than $4, would such fee be retroactive to all examinations occurring subsequent to the date of the enactment of the law, or merely to those examinations made after the County Board has established the fee?

"(2) Would the county of residence of the person examined have to pay the medical fee at the rate established by the County Board in which the examination was made, even though that rate is higher than the rate established by the County Board in the county of residence?"

The opinion rendered by John E. Martin is as follows:

"In our opinion in the event the county board acts to establish a fee for the examining physician as provided by sec. 51.07 (2) Stats. as amended by Ch. 342, Laws of 1945, at a sum greater than $4, the increased fee could only be paid such a physician for examinations made and certificates furnished after the action taken by the county board in increasing the fee becomes effective. This construction follows from the words "as previously determined by the county board" as used in said subsection, which by their context made it plain that the right to receive a fee in a sum greater than $4 must be preceded by action by the county board. The presence of these words in this subsection precludes the possibility of adopting a construction having a retroactive effect so as to permit payment of the higher fee for examinations made prior to action by the county board in increasing the fee, even though the latter construction were otherwise permissible, as to which we express no opinion here.

"We are further of the opinion that the county in which the person examined resides must reimburse the county from which said person was committed at the rate established by the county board of the latter county even though that rate is higher than the rate established by the county board of the county where such person resides. In our opinion the language of sec. 51.07 (4) is so clear on the point that no further comment is necessary."

State Board of Health, Services, Laws, and Rulings

Members of the State Board of Health meet once a month to consider matters pertaining to the life and health of Wisconsin's citizens. Seven members are appointed by the governor and the Board selected an eighth who serves as secretary and state health officer. From left to right: Drs. C. A. Harper, medical specialist in public health; and board members C. W. Eberbach; S. E. Gavin; W. T. Clark; Gunnar Gundersen, president; I. F. Thompson, vice-president; Stephen Cahana; A. E. Rector and C. N. Neupert, state health officer.

E. H. JORRIS

Newly appointed Assistant State Health Officer, Doctor Jorris was graduated from the University of Minnesota Medical School in 1929, and holds a master's degree in public health from the University of Michigan.

Doctor Jorris was located at Sparta as district health officer before becoming director of the tuberculosis division and the local health services of the State Board of Health in 1941.

Entering the Navy in 1943, Doctor Jorris attained the rank of commander before his discharge.

District Health Offices

THE state has been divided into nine districts by the State Board of Health with a full time medical officer in charge of public health activities in each district. An advisory public health nurse, sanitary engineer and secretary make up the staff in each office. The personnel of these offices is available upon request for consultation on any questions pertaining to public health, control of communicable disease, public health nursing or sanitation. Due to the loss of personnel as a result of the war, it has been necessary to combine districts. A list of the district health offices, medical director and the counties included in each district follows:

District Office No. 1—State Office Building, Madison

Health Officer: Dr. A. V. de Veneu

Counties included: Crawford, Richland, Sauk, Columbia, Dane, Green, Lafayette, Iowa and Grant

District Office No. 2—Municipal Bldg., Elkhorn

Health Officer: Dr. Raymond N. Nelson

Counties included: Jefferson, Rock, Waukesha, Walworth, Milwaukee, Kenosha and Racine

District Office No. 3—Court House, Fond du Lac

Health Officer: (Vacancy)

Counties included: Winnebago, Sheboygan, Calumet, Dodge, Manitowoc, Washington, Fond du Lac and Ozaukee

District Office No. 4—City Hall, Sparta

Health Officer: (Vacancy)

Counties included: La Crosse, Waushara, Green Lake, Monroe, Juneau, Vernon, Adams and Marquette

District Office No. 5—Armory, Wisconsin Rapids

Health Officer: Dr. Arthur L. Van Duser

Counties included: Pepin, Clark, Buffalo, Wood, Trempealeau, Marathon, Jackson and Portage

District Office No. 6—City Hall Annex, Green Bay

Health Officer: Dr. Marshall W. Meyer

Counties included: Waupaca, Kewaunee, Shawano, Door, Oconto, Brown, Marinette and Outagamie

District Office No. 7—Box 36, Chippewa Falls

Health Officer: (Vacancy)

Counties included: Polk, Dunn, Barron, Rusk, Chippewa, Pierce, St. Croix and Eau Claire

District Office No. 8—P. O. Box 269, Rhinelander

Health Officer: Dr. Francis Cline

Counties included: Taylor, Price, Lincoln, Oneida, Forest, Vilas, Florence and Langlade

District Office No. 9—Vaughn Library Building, Ashland

Health Officer: (Vacancy)

Counties included: Douglas, Bayfield, Burnett, Washburn, Ashland, Sawyer and Iron

Communicable Diseases

Quarantinable diseases.—Cerebrospinal meningitis (epidemic), cholera (Asiatic), diphtheria, plague, scarlet fever, smallpox, typhus fever, yellow fever.

Placardable diseases.—Chickenpox, infantile paralysis, influenza, leprosy, measles, German measles, typhoid fever, whooping cough.

Reportable only.—Amebic dysentery, epidemic sore throat, erysipelas, infectious encephalitis, malaria, mumps, ophthalmia neonatorum, pneumonia (lobar), trachoma, tuberculosis, tularemia and undulant fever.

Reporting of cases.—A physician is required to report to the health officer within twenty-four hours all cases of communicable disease. Sec. 143.04 (All suspected cases must be reported and considered as positive until a correct diagnosis can be made. Any neglect or refusal of a physician or householder to report cases of communicable disease makes him liable to a severe fine.)

Privilege under quarantine.—Physicians are among the few individuals specified by law as permitted to enter premises quarantined for communicable disease. The expense of maintaining quarantine, including examinations and tests for disease carriers, provided this is done under direction of the local board of health, and the enforcement of isolation, shall be paid by the town, village or city, but the expense in treating communicable disease is not necessarily an obligation of the local board of health, and the local authorities cannot be held liable unless prior arrangement has been made with the physician. Sec. 143.05.

Vaccination for smallpox.—When vaccination or exclusion from school is ordered because of the appearance of a case of smallpox in the community, the local board of health shall provide for the free vaccination of the children of the municipality at municipal expense. Sec. 143.13(3). Parents may employ physicians of their own choice to perform vaccination of their own children but must pay the expenses incurred.

During the year 1945 there was only one change in the rules of the State Board of Health upon communicable disease. Infantile paralysis was made a placardable disease instead of a quarantinable one. The former rule required a three weeks' quarantine of the patient and adults in the home who could not be disassociated from the patient, and also of the children contacts in the home. It appeared to be the general opinion that this was too drastic for the results attained. The placard now required is a warning sign against entering the home and the present rule is to the effect that the patient and children in the home shall remain isolated from the public for two weeks and that the children contacts living outside the home shall remain isolated for two weeks instead of the ten days required in the former rule.

There were some changes made by the legislature upon the basic laws on reporting and quarantining of communicable disease. The old law upon reporting, drawn many years ago, required that all reports be made by physicians to health officers must be upon furnished blanks. The newly worded law permits the report to be made by telephone, telegraph, mail, or to be left at the home or office of the health officer, and where the report is made by telephone the health officer shall fill out a permanent record of the name, age, sex, and such other facts as are required and which are to be given by the physician who telephones. As formerly all reports shall be made within 24 hours of diagnosis.

The state law upon quarantine has a clarifying rewording upon the procedures of the health officer. Paragraph 3 of that law now reads as follows: "When a health officer shall suspect or be informed of the existence of any communicable disease, he shall at once investigate and make or cause such examinations to be made as are necessary. The diagnosis of the physician or the notification or confirmatory consent of the parent or caretaker of the patient or a reasonable belief in the existence of such disease shall be sufficient evidence and having any of these the health officer shall immediately quarantine, placard, isolate or require restrictions in such manner upon such persons and for such time as the State Board of Health provides in its rules. If he be not a physician, his local board of health or appointive body shall employ one to aid

him as speedily as possible where there is reasonable doubt or disagreement in diagnosis and where advice is needed."

The old law had incorporated within it the names of the placardable diseases and the new law deletes these names and permits the State Board of Health to name by rule the diseases which shall be quarantined and placarded, thus permitting of any addition or change that should be made in emergency or between legislative sessions.

Venereal disease.—All physicians and certain institutions are required to report directly to the State Board of Health all persons with venereal disease in a communicable state who come to them for treatment. Sec. 143.07.

A printed form, serially numbered, furnished by the State Board of Health, is used for reporting. Printed instructions for the patient are attached to this report blank and are required to be given to him. Secrecy is imposed upon the State Board. Sec. 143.07.

The State Board of Health requires that the source of infection be investigated and reported back to the Board for the purpose of investigation. All persons having a venereal disease must remain under treatment until the disease is no longer communicable. Discontinuing treatment may be the cause for commitment to an institution until the disease is no longer communicable. Investigation in cases not under treatment may be made by an officer of the State Board of Health, or, when so directed by the State Board of Health, by any local health officer who is a physician. Sec. 143.07 (2), (4), (5).

Drugs commonly used for treatment of syphilis are furnished by the State Board of Health on request to physicians submitting morbidity reports as required by the U. S. Public Health Service. Physicians having patients unable to pay for treatment for venereal disease may assign such individuals to state clinics for treatment.

When a patient refuses treatment the physician shall notify the State Board of Health, giving particulars, to enable the Board to act, and, if necessary, to have the person committed for treatment. In counties of over 250,000 population, the county board may designate the county institution where such commitments may be made. Such persons may be summoned before any court of record or a warrant may be issued for them. Sec. 143.07(5).

When a physician has reported a case of venereal disease to the State Board of Health, all questions regarding the presence of the disease and the date from which treatment was neglected shall not be regarded as privileged information when the patient or physician is called upon to testify to the facts before any court of record. Sec. 143.07(7).

Physicians shall be furnished free of charge with the results of examinations for the diagnosis of gonorrhea made by any state laboratory, and of examinations of blood or secretions for the diagnosis of syphilis from the Wisconsin Psychiatric Institute. Sec. 143.07 (10).

Any city or county may require that persons convicted of acts involving moral turpitude shall undergo a medical examination for the presence of a venereal disease.

No physician or health officer shall issue a certificate of freedom for any person except those certificates required by law for marriage licenses and those required by local ordinances to be issued to local health officers. No person shall carry or exhibit such certificates to other persons, or show, for immoral purposes, venereal disease reports from any laboratory.

All cases of venereal disease shall be regarded as communicable until the following requirements have been met: Until open sores are healed; until satisfactory care and treatment have been given pregnant women with syphilis, females who have given birth to a syphilitic child, syphilitic persons at any stage of the disease who reasonable evidence indicates are promiscuous in sexual relations and are a menace to others, and persons with early syphilis not adequately treated. Trained public health nurses and health officers are available to physicians in the state, from the State Board of Health, for finding and holding cases of venereal disease.

Physician protected from liability.—A physician who reports to the State Board of Health the name of a person afflicted with a venereal disease on account of such person not continuing treatments until the disease is no longer communicable will be protected from liability, if the facts justify his action. 8 Atty. Gen. 561.

Infant blindness.—The attending physician (or midwife) is required to use a 1 per cent silver nitrate solution in the eyes of newborn babies. For the prevention of ophthalmia neonatorum the State Board of Health is required to supply the solution free to every physician (and midwife), put up in proper containers and distributed to health officers for delivery to practitioners.

When ophthalmia neonatorum appears in any newborn babe not attended by a physician or midwife and the case is reported, as required, to the health officer, a competent physician shall be employed by the municipality to examine and treat the infant as directed in the instructions accompanying the solution. The penalty for violation of any part of this law is a fine up to $100. Sec. 146.01.

Laboratory examination for venereal disease.—The state laboratory of hygiene and branch and cooperative laboratories shall make microscopical examinations for the diagnosis of gonorrhea, and the Psychiatric Institute the necessary examinations of blood or secretions for the diagnosis of syphilis, for any physician in the state, without charge.

The law requires that all laboratories doing tests for syphilis and gonorrhea report their positive tests together with the name of the physician making the test on blanks provided by the State Board of Health.

Venereal disease, indigents. — The county is required to pay for the care and treatment of indigent persons afflicted with a venereal disease. 8 Atty. Gen. 559.

The county is responsible for one-half of the per capita cost for the care and treatment of indigents committed to state institutions for the treatment of venereal disease. Sec. 143.07 (6).

Tuberculosis.—Every physician is required to report within one week cases of tuberculosis in his care or under his observation. The report shall contain the name and address, age and sex of the case. Report blanks will be furnished by the State Board of Health.

Voluntary admission to a tuberculosis sanatorium in Wisconsin can be obtained (Chapter 50) by having the patient or his representative appear before a county judge of the county in which he has legal settlement or in which he is residing. If the patient has a legal residence or has resided in the state for an aggregate of five years or more, he may be admitted without charge. Report of the examining physician and judge's orders are transmitted to the sanatorium where the patient may be admitted by the superintendent when a vacancy occurs.

Services of Maternal and Child Health

Lecturers For Medical Societies. The Bureau of Maternal and Child Health has a special fund which may be used to assist medical societies in obtaining lecturers in the fields of obstetrics, pediatrics, and preventive mental health.

Child Guidance Clinics. The demonstration clinics in child guidance have been taken over and are operating under local auspices (Brown, Racine, Rock, Walworth, and Winnebago counties). Demonstrations continue or plans are pending for local support in Dane, Dodge, Fond du Lac, and Sheboygan counties, with established local centers in Kenosha, Milwaukee, and Waukesha counties.

Because of their interest in mental health and their responsibility in this field, Wisconsin physicians will be glad to know that there are an increasing number of child guidance centers under psychiatric directors to which they may turn with problems in this field. The early control of behavior disorders offers the best opportunity for promoting good adjustment in later life.

School Health. The attention of physicians participating in school health programs is directed to teaching aids and educational material available to schools through the Bureau of Maternal and Child Health. The physicians will be interested in the type of health guidance cards now in use in many of the schools throughout Wisconsin as an appraisal sheet of the individual child.

Nutrition. Although a large part of the activities in this field are in connection with the school program, advisory service is always available to physicians on request either in regard to problems with their patients or for institutions they serve if such institutions do not have the services of a trained dietician or nutrition specialists. Educational literature for all age groups is available upon request.

Classes For Graduate Nurses. Doctors may wish to encourage local hospitals to take advantage of stipends available for sending obstetric or pediatric staff nurses to Milwaukee for special training in care of premature babies. The courses available are set up as a 2-month graduate course at Marquette University with hospital experience at St. Joseph's Hospital. Stipend forms are available through the Bureau of Maternal and Child Health upon request.

Incubators. Any physician needing an incubator for a premature infant born at home or for care of prematures upon release from the hospital should contact the local public health nurse or district health office. Incubators are now readily available in all parts of the state, and local public health nurses will demonstrate their use and make home visits to assist the family in following the physician's instructions when an incubator is needed for care of a premature infant born at home. These incubators can also be used for releasing infants that are still in incubators from hospitals.

The present Board of Health incubators are not safe for use in the presence of free oxygen except when heated with other means than electricity. However, an effort is being made to obtain a type of thermostat that will be safe in the presence of free oxygen so that these incubators may be made available for hospital use because such a high percentage of deliveries are now in hospitals.

Prenatal Letters. Many physicians regularly enroll their obstetric cases for the prenatal letter service. Special forms are provided for this. Patients enrolled receive the booklet on prenatal care, wall card, health habits in pregnancy, and monthly letters during pregnancy. Later the booklet on infant care is provided, with diet and development cards for the first two months. At intervals through the first year of the infant's life letters and diet and development cards are sent to remind mothers of the need for returning to the physician for health supervision, immunization, and vaccination.

Literature. Physicians may obtain supplies of any of the literature available through the bureau for their own office use. They are, however, urged to avoid duplication of distribution as far as possible. Similar literature is sometimes distributed by the county nurses and much of the material goes

to any woman enrolled for the prenatal letter service. EMIC cases are routinely enrolled for this service and there are many other requests from the doctors throughout the year.

State Laboratory of Hygiene

Physicians shall be furnished free of charge with results of laboratory analyses of specimens sent for determining diagnosis of disease. Laboratories are located at Madison, Rhinelander, Oshkosh, Green Bay, Superior, Beloit, Kenosha, Wausau, Sheboygan and La Crosse.

The materials which are examined in these laboratories are sputum for tubercle bacilli; swabs for diphtheria bacilli and other organisms; pus for gonococci and other organisms; central nervous systems of dogs and other animals for Negri bodies diagnostic of rabies; spinal fluid for meningococci and other organisms; materials in suspected cases of anthrax, glanders and actinomycosis; blood, feces and urine for the diagnosis of typhoid and paratyphoid fever (blood only for tularemia and undulant fever) or to detect carriers of these germs; and chemical and bacteriologic examination of water to detect its fitness for drinking purposes. The examination of tissue in suspected cases of malignancy is done only in the laboratory in Madison, and only in those cases wherein the patients are unable to pay a special fee. Such tests are made free for physicians, and the facilities of the laboratories are urged upon the physicians of Wisconsin in the effort to detect and combat communicable disease. Pneumonia typing is now a valuable service offered by the laboratories.

State **biologic products.**—Under the law, local boards of health are required, under the direction of the State Board of Health, to furnish antitoxin to indigents suffering from communicable diseases. The State Laboratory of Hygiene at Madison has available for distribution free of charge to physicians in the state typhoid-paratyphoid vaccine and whooping cough vaccine. Tuberculin diluted 1 to 1,000 is available for group testing by the Mantoux test.

Vital Statistics

The 1945 session of the legislature has made further changes in the Vital Statistics law, Chapter 69, Wis. Statutes, which simplify the procedure of filing vital records.

Birth Records. There are no changes in the procedure for filing birth records. The attending physician is required to prepare and file individual original birth records within five days after birth with the city health officer of the city in which birth occurred and, if birth occurred outside the limits of any city, with the register of deeds of the county in which such birth occurred.

Blanks for original birth records are furnished free by the state registrar and can now also be obtained from any city health officer or register of deeds.

69.09. Districts and local health officers. For the purpose of this chapter each county shall be a primary registration district for villages and towns and the register of deeds' office shall be the place for filing. The primary registration district for any city shall be the city and the office of the local health officer the place for filing. The local registrar shall be the health officer or commissioner of health in cities.

69.10. Local statistics; copies; filing. Each register of deeds and city health officer shall collect and file certificates of births, stillbirths, deaths and marriages that occur in his county or city as provided in Section 69.09, and after making a copy thereof transmit the original to the state registrar. In addition, city health departments are required under Section 69.18 (3) to * * * transmit within five days of the original filing a copy of the original certificate of birth, stillbirth, death or marriage to the register of deeds of the proper county. There have been many complaints from registers of deeds that this legal provision is ignored by city health departments. With the continued demand and need for certified copies of these records by members of the Armed Forces as well as by the general public, it is essential that city health officers comply with this requirement.

In Milwaukee County the register of deeds and the city health officer are now required, within ten days after the filing of an original birth certificate, to make an exact copy of such birth record whenever the parents of the child born were residents of any town or village in Milwaukee County and transmit such copies to the town or village clerk without any charge therefor.

Sections 69.19 and 69.20 requiring registration of physicians, midwives, undertakers, funeral directors with the register of deeds or the city health officer have been repealed. They are therefore no longer required to register with these two agencies.

Death and stillbirth certificates. Burial permits. There are no changes in the procedure for preparing these certificates as provided by Sections 69.38 and 69.45:

69.38. Physician's Certificate, Causes of Death. (1) The certificate of death shall be made and signed by the physician last in attendance on the deceased and shall specify the time in attendance, the time he last saw the deceased alive, and the hour and the day at which death occurred.

(2) He shall state the causes of death so as to show the course of disease or sequences of causes resulting in death, and the duration of each.

(3) Indefinite and unsatisfactory terms indicating only symptoms of disease or conditions resulting from diseases are not sufficient for issuing a burial or removal permit and any certificate containing only such terms shall be returned to the physician for correction and definition.

(4) Causes of death which may be the result of either disease or violence shall be carefully defined, and, if from violence, its nature shall be stated, and whether accidental, suicidal or homicidal.

(5) In case of deaths in hospitals, institutions or away from home, the physician shall furnish the information required under this head and shall state where, in his opinion, the disease was contracted.

(6) And the cause of death and all other facts required shall in all cases be stated in accordance with the rules and regulations of the state registrar.

69.45. Funeral Director's Duties as to Certificate and Permit. (1) The funeral director, or person acting as funeral director, shall be responsible for obtaining and filing the certificate of death with the registrar and securing from him a burial or removal permit prior to any disposition of the body.

(2) He shall obtain the personal and statistical particulars required from the person best qualified to supply them over the signature and address of his informant. He shall then present the certificate to the attending physician or other person authorized by law to fill out the medical certificate of the cause of death and other particulars necessary to complete the record, as specified in Sections 69.35 to 69.41. He shall then state the facts required relative to the date and place of burial over his signature and his address and present the completed certificate to the registrar who shall then issue a burial or removal permit.

(3) The undertaker shall deliver the burial permit to the sexton or person in charge of the place of burial before interring the body, or attach the removal permit to the box containing the corpse, when shipped by any transportation company, to accompany the same to destination.

The procedure for filing death and stillbirth certificates is now identical with that for filing birth records. Death and stillbirth certificates for such events occurring within a city must be filed with the city health officer and those occurring outside any city with the register of deeds of the proper county.

Three agencies are now specifically authorized to issue burial permits in accordance with Section 69.42: Burial and Removal Permits.

69.42. (1) The register of deeds, city health officer and the clerk of any incorporated village are authorized to issue a burial or removal permit.

(2) If any certificate of death or stillbirth is incomplete or unsatisfactory, it shall be the duty of the officer authorized to issue burial or removal permits to call attention to the defects in the certificate and withhold the issuance of the burial or removal permit until a complete and satisfactory record is furnished.

(3) When the death or stillbirth record is presented to the clerk of any incorporated village for the issuance of a burial or removal permit, the village clerk shall forthwith transmit the original record to the register of deeds if the death or stillbirth occurred in a town or village or to the city health officer if the death occurred in a city.

It should be noted that these agencies are authorized to issue burial permits regardless of where within the State of Wisconsin death occurred. Since burial permits cannot be obtained except against delivery of the original death or stillbirth certificate, the agency issuing the burial permit is required to transmit the original certificate forthwith to the proper city health officer or register of deeds, depending on where death actually occurred. Only the city health officer or the register of deeds of the city or county where death actually occurred will insert the date of filing and signature as local registrar.

Recent New Changes in Laws Affecting the Care of the Tuberculous*

PHYSICIANS will be interested in two changes in laws affecting the care of their tuberculous patients. A new law providing for the free care of the tuberculous became effective on May 5, 1945. Under the provisions of this bill, any legal resident of a municipality of the State of Wisconsin is entitled to free care when he enters a tuberculosis sanatorium, provided that he does not wish to pay for part or all of his care and provided that he has no hospital insurance which covers his care. Should he have hospital insurance, it will apply on his care for the period of time specified in the policy and any difference between the amount which the policy pays and the amount necessary for his complete maintenance is to be at public expense. At the expiration of his policy he becomes a full public charge.

A state-at-large case must have resided in this state for a total of five years sometime prior to admission to the sanatorium, and if he be a minor, the resident requirement applies to his parent or guardian. If he has not resided in the state 5 years, then it still remains up to the county judge to determine whether or not such a state-at-large case has the ability to pay for his care.

The other change refers to the commitment law which was strengthened. Formerly it was necessary to have the diagnosis of tuberculosis confirmed by a positive sputum in a state laboratory or a municipal laboratory approved by the State Board of Health before the patient could be committed to a sanatorium. Under the amended provisions which went into effect June 7, 1945, a person may be committed if his diagnosis has been made by a medical examination, a laboratory, or an x-ray examination if he fails to comply with the State Board of Health rules and regulations relating to the disease.

Extracts from Section 143.06 of the Wisconsin Statutes follow:

"(2) Every person sick with tuberculosis, or in attendance, and the authorities of such places, shall observe and enforce the rules and regulations of the health board for preventing spread.

* Prepared for the Journal by Allan Filek, M. D., Director, Division of Tuberculosis, State Board of Health.

"(4) If any person afflicted with tuberculosis, diagnosis of which is made by a medical examination, laboratory or X-ray examination or as shown by the examinations made in the state laboratory of hygiene, in any branch and co-operative laboratory or in any municipal laboratory accredited by the state board of health or in any federal governmental laboratory, fails to comply with this section, or the tuberculosis rules of the state board of health, he may be committed to a county tuberculosis hospital or other place or institution where proper care will be provided and where the necessary precautions will be taken, by any judge of a court of record upon proof that such person has so offended. Such person shall, upon verified petition setting forth the facts by any health officer or any resident of the municipality where the alleged offense was committed, be summoned by such judge to appear at the time and place stated in the summons, which time shall not be less than 48 hours after service. The court may make such order for payment for care and treatment as may be authorized by law. Such person may be discharged when the court thinks proper. If the superintendent has good cause to believe that any person so committed may leave the institution he may restrain him from leaving. Whenever the superintendent deems it necessary he may segregate any person so committed. If any person so committed shall escape, the superintendent may take such lawful steps as he may deem necessary to secure his return. * * *"

The rules and regulations which the infected individual must comply with are quoted in part as follows:

"All individuals afflicted with tuberculosis of the lungs in the communicable form or reasonably suspected of being so afflicted shall exercise all reasonable precautions so as to prevent the infection of others with whom they may come in contact. The principal reasonable precautions are declared to be:

1. Depositing sputum in a special receptacle and disposing of material by burning or thorough disinfecting.
2. Preventing spraying when coughing by coughing into a container or paper napkin held to the mouth or nose.
3. Using individual eating utensils sterilized by boiling after each use.
4. Using separate towels.
5. Sleeping alone.
6. Avoiding coming in contact with other persons on all possible occasions.
7. Refraining from handling liquids or foodstuffs to be consumed by others or the utensils connected with such handling.

"Any individual afflicted with tuberculosis of the lungs in the communicable form, diagnosed as such by a licensed physician or as shown by X-ray or the presence of tubercle bacilli in the sputum, in order to protect others from becoming infected, may be quarantined on his premises by the local board of health or the health officer on the direction of the State Board of Health or State Health Officer, or by the full-time Medical Health Officer of any city or county with a population of 250,000 or more within his jurisdiction.

* * *

"No person with tuberculosis of the lung or other part of the respiratory tract in the communicable form, or reasonably believed to be suffering from such disease, shall be permitted to attend or frequent any school except open-air schools especially equipped for the purpose until the health officer of the municipality where the school is situated furnishes a written certificate stating that the individual is free from a communicable form of tuberculosis. Such certificate shall only be issued after thorough examination by a licensed physician in a manner satisfactory to the State Board of Health.

* * *

"If an individual afflicted with tuberculosis in a communicable form shall leave the sanatorium against the advice of the medical superintendent or medical supervisor, such an individual shall be reported to the local board of health and may be quarantined upon his premises as provided in Section B if in the opinion of the State Board of Health or the State Health Officer or of the full-time Medical Health Officer of cities or counties with a population of 250,000 or more, agree that quarantine is necessary in order to protect others from becoming infected."

Emergency Maternity and Infant Care*

THIS war program, set up by Congressional Act, was designated "for the duration and until six months thereafter." Recent Congressional action postponed for official action in 1946 any consideration of pending bills for declaring the war at an end. EMIC therefore continues into 1946 with the modification of eligibility as provided in 1945. The change in requirement for consultants which became effective October 1, 1945, continues in effect. Many physicians promptly cooperated in filing the questionnaires sent to determine their training and the physicians whom they normally call in consultation. However, there are some areas in the state from which these forms have not been returned, which is a factor in slowing authorizations for consultation services.

* From the Bureau of Maternal and Child Health, Wisconsin State Board of Health.

Through December 15, 1945, medical and hospital care had been provided under EMIC for approximately 22,000 individuals. About 12 per cent were requests for pediatric care.

Special Reminders on EMIC

Eligibility. 1. Any woman whose husband was in one of the four lowest pay grades of the armed forces at any time during the pregnancy for which care is requested, regardless of subsequent promotion or honorable discharge, is eligible for care.

2. Any sick infant under one year of age whose father was in one of the four lowest pay grades at any time during its prenatal period or first year of life, regardless of subsequent promotion or honorable discharge, is likewise eligible. (Well-baby supervision, immunizations, and vaccinations are not included under the plan.)

Because of the change in eligibility it is very important that care be given to ascertain and verify the rank of the husband at time pregnancy occurred.

Pediatric Application. The mother's eligibility for care establishes the eligibility of her infant for care when ill during the first year of life. However, in order that authorizations can be issued and the necessary forms sent to physicians and hospitals, it remains necessary to file pediatric applications for each illness and to request special services as in the past.

Authorizations. When care is provided under terms of EMIC, authorizations once issued remain in effect even though the husband may be discharged from service.

Consultations. When surgery is necessary or when consultations are required to meet other obstetric or pediatric needs, the qualifications which became effective October 1, 1945, should be kept in mind. In areas where available, consultants should be physicians certified by their specialty board, eligible for such certification, or physicians with at least one year of special training and experience in their specialty. In areas where no such specialists are available, consultations can be authorized to individuals qualified by training or experience and normally called for such services within the community in which they practice.

Care Covered by Authorizations. In filing applications for care, physicians agree to provide at the rates in effect under EMIC all care required for conditions associated with pregnancy without making additional charges to the patient or anyone in her behalf for any care rendered within the preiod of authorization. Some physicians do not realize that *they may request* additional payment for *intercurrent conditions not associated with pregnancy which require home or hospital visits.* When such care is requested, separate authorizations are issued and cleared as special payments at the rates in effect for care of intercurrent conditions.

Prompt return of vouchers after care is completed facilitates prompt payment and closing of cases.

PROFESSIONAL DISCOUNTS

Many physicians have at some time entered into contracts with pharmaceutical supply houses under which a professional discount was allowed. These contracts may be drawn initially to extend for a year from the date of execution. However, it frequently occurs that after the term of the original contract has run, the physician continues to make purchases with the expectation that the discount will be continued. This expectation is not always realized and the result is a dispute between the supply house and the physician.

Because honor and integrity alone will not prevent dispute or dissipate it, it is well to remember that contracts, other than those of lease, do not automatically renew themselves so as to incorporate all terms of the original agreement unless specific provision therefor is made. Thus there is no reason why the supply house legally could not refuse the discount as to purchases made after the expiration of the original contract, whatever the physician many have assumed as to renewal.

Many supply houses undoubtedly extend discounts beyond the original term as an expression of good will. Because some of them do not, however, it is wise to **examine your contract critically noting the date of expiration. Confirm in writing your understanding as to renewal and for what period of time.**

Officers of State Boards and Commissions

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Prof. Robert N. Bauer, Secretary, 152 W. Wisconsin Avenue, Milwaukee, 1947

Prof. William H. Barber, Treasurer, 621 Ransom Avenue, Ripon, 1951

State Board of Medical Examiners

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C. A. Dawson, M. D., Secretary, River Falls, 1947

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A. F. Rufflo, M. D., Kenosha, 1949

E. W. Miller, M. D., Milwaukee, 1949

R. G. Arveson, M. D., Frederic, 1947

J. W. Smith, M. D., 324 East Wisconsin Avenue, Milwaukee, 1947

E. C. Murphy, D. O., Eau Claire, 1949

State Board of Health

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Committee on Nursing Education

R. M. Kurten, M. D., Racine, 1947

Rev. William G. Sodt, Milwaukee Hospital

Rev. Edmund J. Goebel, Superintendent Catholic Schools, Archdiocese of Milwaukee, Milwaukee, 1947

Sister Mercedes, St. Mary's Hospital, Milwaukee, 1947

Miss Esther Klingman, Theda Clark Memorial Hospital, Neenah, 1947

Miss Clara Bumiller, Wisconsin State Nurses' Association, Milwaukee, 1947

Miss Christine Murray, University of Wisconsin School of Nursing, Madison, 1947.

C. N. Neupert, M. D., State Health Officer, Madison

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Mrs. Margaret Gehl, Acting Supervisor, Bureau of Public Health Nursing, Madison

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- Mrs. Ruth McConnell

District Health Officers

1. Madison—A. V. de Veneu, M. D., Wyocena
2. Elkhorn—R. N. Nelson, M. D., Municipal Building

3. Fond du Lac—(Vacancy)
4. Sparta—(Vacancy)
5. Wisconsin Rapids—A. L. Van Duser, M. D., Armory
6. Green Bay—M. W. Meyer, M. D., City Hall Annex
7. Chippewa Falls—(Vacancy)
8. Rhinelander—Frances Cline, M. D., Box 269
9. Ashland—(Vacancy)

State Board of Public Welfare

(Created by act of 1939 legislature to supplant the State Board of Control, and combining certain other agencies.)

Members of the Board

Mr. Herman A. Kloppmann, Chairman, Crivitz, 1951
Mr. John M. McHale, Vice-chairman, Green Bay, 1951
W. D. Stovall, M. D., Secretary, Madison, 1949
Mr. Charles H. Liehe, Chippewa Falls, 1947
Mrs. H. L. Garner, Madison, 1947
George R. Baker, M. D., Tomahawk, 1949
Leo M. Novak, D.D.S., Milwaukee, 1951

Executive Staff

Mr. A. W. Bayley, Madison, Director

Division of Corrections:
Mr. Paul D. Yount, Director

Division of Mental Hygiene:
W. J. Urben, M. D., Madison, Director

Division of Public Assistance:
Mr. George M. Keith, Madison, Director

Division of Administration and Research:
Mr. H. B. Evans, Madison, Acting Director

Division of Child Welfare:
Miss Elizabeth Yerxa, Madison, Director

Division of Adult Blind Services:
Mr. E. F. Costigan, Milwaukee, Director

Wisconsin Industrial Commission

Members of the Commission

Mr. Voyta Wrabetz, Chairman, 1949
Mr. Harry J. Burczyk, 1947
Mr. C. L. Miler, 1951
Miss Helen Gill, Secretary

Workmen's Compensation Department

Mr. Harry A. Nelson, Director

Unemployment Compensation Department

Mr. Paul Raushenbush, Director

Safety and Sanitation Department

Mr. Robert McA. Keown, Director

State Board of Vocational and Adult Education

Employee Members

E. J. Fransway—Wauwatosa
Emil Waldow—Green Bay
Frank C. Horyza—Superior

Employer Members

Jessel S. Whyte—Kenosha
Alfred A. Laun—Kiel
Fred Vogt—Milwaukee

Farmer Members

John Last—Lake Mills
John Wiechers—Racine
Robert L. Pierce—Menomonie

Ex-Officio Members

John Callahan—Madison
Voyta Wrabetz—Madison
C. L. Greiber—Madison
State Director, State Board of Vocational and Adult Education

Rehabilitation Division

State Office

Room 320, State Office Building, Madison, Wisconsin

W. F. Faulkes—Chief
J. H. Brown—Assistant Chief

State Supervisory Staff

O. H. Johnson—Research and Promotion
Chas. Beardsley—Case Service
Irene M. Dunn—Records
A. E. Towne—Physical Rehabilitation
Mary F. Beyer—Homecraft

District Offices

Madison—114 North Carroll Street
C. D. Rejahl, District Supervisor
Milwaukee Vocational School Bldg.
—1015 N. 6th Street
L. A. Rumsey, District Supervisor
Green Bay Vocational School Bldg.
—200 S. Broadway
A. W. Bouffard, District Supervisor
Eau Claire Vocational School Bldg.
—1300 First Avenue
F. A. Campbell, District Supervisor

Local Offices

Carl Haase—Assistant Case Supervisor
La Crosse Vocational School Building
V. C. Bryan—Assistant Case Supervisor
Racine Vocational School Building
L. H. Heise—Case Supervisor
Wausau Vocational School Building
H. C. Ritzman—Assistant Case Supervisor
Superior Vocational School Building

STATE MEDICAL ADVISORY COMMITTEE

T. J. Howard, M. D.—Milwaukee
G. F. Wakefield, M. D.—West Salem
J. K. Trumbo, M. D.—Wausau
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R. M. Kurten, M. D.—Racine
H. L. Greene, M. D.—Madison
H. M. Coon, M. D.—Madison
C. N. Neupert, M. D.—Madison
Charles Fidler, M. D.—Milwaukee
H. H. Reese, M. D.—Madison
H. J. Heeb, M. D.—Milwaukee
Miss Marjorie Taylor—Milwaukee

PHYSICIAN MEMBERS IN RECONVERSION

During the past several years, as an increasing number of Wisconsin physicians have been actively identified with the armed forces, the Blue Book issue of *The Wisconsin Medical Journal* has carried various articles concerning legal aspects of medical practice in relation to military service. Because during the ensuing year most physician members will return to civilian practice the *Journal* has omitted publication of several articles specifically pertaining to professional matters related to military service,* and is rather stressing the transition from military service to civilian practice as well as relationships which will be established by all physicians in the handling of medical services to veterans, either through the Wisconsin Department of Veterans Affairs or the Veterans Administration.

It is hoped that we have outlined in the following pages some of the more important points which will serve to inform our readers on topics of current importance.

* "The Amended Soldiers' and Sailors' Civil Relief Act," "Life Insurance and the Physician in Service," "Medical Officers' Pay, Allowances and Rank," and "Medical Advisory Boards." See the January, 1945, issue of *The Wisconsin Medical Journal,* pages 123–133.

Points to Remember

Suggestions to Physicians in Service Establishing or Re-establishing Themselves in Civilian Practice

AS WISCONSIN physicians are being released from military service many inquiries have reached the office of the State Medical Society relative to problems involved in the establishment or re-establishment of civilian practice. As a guide to returning veterans the *Journal* lists below a few suggestions or reminders which may prove helpful:

Waiving of State Dues: By action of the Council of the State Medical Society all state dues of veteran members will be waived for a period of six months following discharge, and thereafter prorated for so much of the calendar year as may remain.

In order to keep all records accurate please send the secretary's office in Madison a statement as to when your terminal leave ENDS and you officially return to civilian status.

* * *

Professional Opportunities: The office of the secretary, 917 Tenney Building, Madison 3, is serving as a clearing house, in cooperation with Procurement and Assignment service, for all information as to communities in need of medical services as well as current information on available residencies. A list of residencies in Wisconsin hospitals was carried in the J. A. M. A., September 29 issue, and is reprinted in the November issue of *The Wisconsin Medical Journal.* When considering available locations, a review of the files in the Madison office may be helpful.

* * *

Registration of Your License: All physicians beginning practice or locating in a new community are reminded that they should record their license with the clerk of the county where the physician resides. The recording fee is 50 cents. Non-residents shall file such licenses in each county in which they practice. Until such license has been issued and recorded no person may practice or attempt to hold himself out as authorized to practice medicine and surgery. If you have mislaid your license communicate with C. A. Dawson, M. D., Secretary of the Wisconsin Board of Medical Examiners, River Falls, Wisconsin.

Annual Registration: Commencing in 1944 every person licensed to and engaged in or entering upon the practice of medicine and surgery, or osteopathy, or osteopathy and surgery shall in January of each year register with the Secretary of the Wisconsin State Board of Medical Examiners and shall notify the State Board of Examiners within thirty days of any change of residence or professional address. The fee is $3.

The provisions of the law regarding the annual registration are suspended under Section 14.77 of the Wisconsin Statutes as to those in the active service of the armed forces of the United States. However, that suspension section provides that one holding a license "shall apply for registration within six months of the date of discharge from the armed forces."

* * *

Malpractice Insurance: Many members, upon entrance into military service, either permitted their malpractice insurance to lapse or modified the extent of coverage in keeping with changed circumstances of practice. In order to avoid any possible trouble due to assumed coverage it is suggested that all those who have heretofore carried malpractice insurance carefully review their current coverage and revise it in keeping with needs which will exist on the basis of contemplated practice.

* * *

Renewal or Application for Narcotic License: A physician desirous of using narcotics or marijuana in the course of his professional practice, who is registering for the first time, may do so at any time of the year. He should first request a narcotics application form from the office of the Collector of Internal Revenue, Federal Building, Milwaukee. This should be carefully filled out, witnessed or notarized, and returned to the collector, together with a special annual tax of $1.

Physicians who have registered before under the narcotics law will receive reregistration Form 678 from the Collector of Internal Revenue in May of each year. This should be carefully prepared and returned along with the annual tax of $1 *on or before July 1 of each year.* A physician who does not receive a reregistration form on or before July 1 is under duty to request one from the collector.

Further regulations are outlined in detail on pages 104–107 of the 1945 Blue Book issue (January) of *The Wisconsin Medical Journal.*

* * *

Loans and Grants: If you are interested in postgraduate work and financial support for further schooling under terms of the GI Bill of Rights and supplementary assistance through state sources, full information can be secured by contacting the Department of Veterans Affairs, State Capitol, Madison. Postgraduate courses at Marquette and the University of Wisconsin Medical Schools are planned to meet existing needs. Current developments can be secured by contacting the deans of the two medical schools.

* * *

Panel Listing: All members in service have been given the opportunity of having their names listed on Workmen's Compensation Panels indicating their military service. Younger members who have not had the opportunity of listing may be listed by insertion of their names on local panels as long as they are members in good standing in their county and state societies. If such members wish to have selected employers in their community contacted, the secretary's office in Madison will be pleased to render this service. A new panel possibly will be issued the latter half of 1946.

* * *

Professional Publicity: Public announcements in reference to establishment or re-establishment of civilian practice should follow the "Principles of Medical Ethics of the American Medical Association," outlined in detail on pages 162–167 of the 1945 Blue Book issue of *The Wisconsin Medical Journal.*

Section 4, related to advertising, includes the following statement:

"The publication or circulation of ordinary simple business cards, being a matter of personal taste or local custom, and sometimes of convenience, is not per se improper. As implied, it is unprofessional to disregard local customs and offend recognized ideals in publishing or circulating such cards."

DO WE HAVE YOUR PICTURE?

All veteran members who have not already sent their pictures (size 6" x 9") and data on military service to the Committee on War Records are requested to do so as soon as possible. Plans are under way to complete a pictorial record of veteran members, but the project cannot be brought to conclusion without the cooperation of all Wisconsin physicians who served in World War II.

COMMITTEE ON WAR RECORDS
R. W. BLUMENTHAL, M. D., *Chairman*
K. K. BORSACK, M. D.,
A. H. GUNDERSEN, M. D.

Conditions Under Which Private Physician and Civilian Hospital Will Be Paid For Care of Disabled Veteran*

WHAT are the regulations of the Veterans Administration pertaining to the treatment of veterans by physicians in private practice and to the hospitalization of veterans in private institutions, as well as city, county or state hospitals?

Under what conditions will the physician in private practice and the civilian hospital be reimbursed for services rendered?

With which officials of the Veterans Administration should the physician in private practice and the civilian hospital superintendent deal on such matters?

These, and similar, pertinent questions are being raised by Wisconsin physicians and hospital officials as an increasing number of discharged service men return home, many of whom are eligible for the services and benefits provided by the Veterans Administration.

Based on Official Advice

This article attempts to answer some of these questions. It is based on information supplied by the chief medical officer, Veterans Administration, Madison, Wisconsin, in answer to a request filed with the Veterans Administration by the office of the Secretary of the State Medical Society of Wisconsin.

Appended are Veterans Administration regulations pertaining to the utilization of facilities other than those under the direct and exclusive jurisdiction of the Veterans Administration which are of special interest to physicians in private practice and civilian hospitals.

Some of the main points covered by the regulations and other information of importance follow:

1. Medical care and attention, whether by private physician or civilian hospital, must have prior authorization of the Veterans Administration before reimbursement may be made, **except in connection with the treatment of a medical emergency arising from a disease or injury which has been adjudicated as service incurred.**

2. If a private physician or superintendent of a civilian hospital encounters such a case, he should get in touch with the Chief, Reception and Out-Patient Service, of the Veterans Administration office nearest the home of the veteran, within 5 days of the first contact with the patient, in order that proper authorization for treatment or hospitalization, or both, may be made.

All Conditions Must Be Met

3. In cases where prior authorization for medical and hospital services is not obtained, reimbursement for the payment of the medical and hospital services may be presented to the Veterans Administration Central Office through the Regional Office or hospital in whose territory the treatment was rendered, **providing all of the following conditions are met:**

(a) The treatment was rendered for a service-connected condition only, or for the relief of an associated nonservice-connected condition, which in the determination of the medical director was aggravating the disability of basic service-connected disorder;

(b) The treatment was rendered in a medical emergency;

(c) Government hospitals were not feasibly available and travel would have been hazardous.

4. Under existing conditions, neither out-patient treatment nor hospitalization in a civilian hospital may be authorized for treatment of **non-service-connected conditions, except in the event that the condition is aggravating a service-connected disability.**

Examiners Designated

5. In the majority of Wisconsin communities the Veterans Administration has designated medical examiners to whom service-connected veterans are referred for treatment and to whom they are directed to apply in event of emergency.

6. Certain hospitals have contracts with the Veterans Administration for the care of service-connected cases when proper authorization has been made.

7. Veterans in training for Vocational Rehabilitation authorized by the Veterans Administration are entitled to treatment or hospitalization, if indicated, for any condition which interferes with the continuation of vocational training, as well as for treatment of service-connected disabilities. However, veterans given training under the G. I. Bill of Rights are entitled to treatment only for service-connected disabilities.

Women Veterans

8. Women war veterans, needing treatment in a medical emergency for a condition **either service-connected or not service-connected,** may be authorized admission to a private hospital not under contract, if a government or private contract hospital is not feasibly available, without procurement of prior approval of the medical director. In such cases, the provisions referred to in paragraphs 1, 2 and 3,

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* Prepared for the *Journal* by Frank C. Fellows, Veterans Administration, Madison, Wisconsin and Lt. Col. Leon K. Gurjian. Based on original publication from the Ohio State Medical Journal, January, 1945.

above, will apply. Care for pregnancy and childbirth is not authorized.

9. Some veterans seeking a pension believe that a statement from their private physician, based on their history alone and not upon the physical findings, will help them obtain hospitalization and subsequently, a pension. This is a misunderstanding. A veteran who has no service-connected disability may not be hospitalized upon his request, or on the recommendation of his private physician, for the purpose of securing examination and observation, since this type of hospitalization is made only upon the authority of the Adjudicating Service of the Regional Office of the Veterans Administration having jurisdiction, or upon the authority of the service in the central office having jurisdiction.

10. There are four Veterans Administration offices in Wisconsin to whom inquiries may be transmitted by physicians and hospitals. They are located at Eau Claire, Green Bay, Madison, and Wood.

Regulations Which Apply

Regulations covering the utilization of hospitals other than those under direct and exclusive jurisdiction of the Veterans Administration, follow:

(A) Hospitalization will not be authorized in government hospitals other than those over which the Veterans Administration has direct and exclusive jurisdiction until agreement covering such service has been approved. Such agreements, which will be only to cover admissions of beneficiaries with service-connected diseases or injuries (except where the Administrator authorizes additional government hospitals to be used for nonservice-connected cases, in which event specific authorization will be granted to the manager of the office or hospital concerned to utilize a particular government hospital and except for beneficiaries in the territories and insular possessions), will not be entered into until careful consideration has been given to the best interests of both the government and beneficiaries.

(B) (1) Private hospitals will not be used for hospitalization of beneficiaries except when hospitals under direct and exclusive jurisdiction of the Veterans Administration or other Federal hospitals are not feasibly available or when the physical or mental condition of beneficiaries will not allow of their transfer from a private, state or municipal hospital to a federal hospital. Except for treatment of an emergent condition arising from a service-connected disorder, hospitalization of a male beneficiary will not be authorized in any private, state or municipal hospital whether under contract or not. In such medically emergent cases, authorization of admission to a private, state or municipal hospital may be given, subject to the conditions stipulated in (2) hereof; and, when so given, will be authority for payment of vouchers covering the cost of such hospitalization.

Instructions to Be Issued

(2) The chief medical officer or his designate, of the regional office or hospital with regional office having jurisdiction of the territory in which the concerned private, state, or municipal hospital, contract or non-contract, is located, when informed of the emergent condition of the entitled beneficiary in time to authorize the hospital admission, or when requested to issue authorization to cover a hospital admission already effected, will at once notify the superintendent of such hospital as follows: (a) That payment can not be made by the Veterans Administration for any hospital service or supplies furnished prior to the date that authorization for admission had been issued, and that such authorization can not be retroactively dated when issued; (except that authorization may be made retroactive to include a period not exceeding 5 days beginning with the hour that admission to the hospital is authorized by the Veterans Administration). (b) That—if the hospital concerned is under contract with the Veterans Administration—all services and supplies furnished the beneficiary must be charged for and paid only at rates in accordance with the terms of the contract. (c) That—if the hospital concerned is not under contract—all services and supplies can be paid for only at rates in accordance with the schedule of fees, Veterans Administration. (d) That, when possible, prior authority will be requested by the hospital for the furnishing of services or supplies other than those included in a contract, or other than those comprehending ordinary items. (e) But when the procurement of such prior authority is not possible, or when the emergent condition of the beneficiary is too urgent for delay, the hospital may furnish such necessary services or supplies, with the understanding that charges therefor will be subject to determination as to their reasonable necessity by the chief medical officer or his designate.

(D) The general principles to be observed in utilization of hospitals other than those over which the Veterans Administration has direct and exclusive jurisdiction will be as follows: Other government hospitals under agreements or private hospitals under contracts will be used for the hospitalization of beneficiaries requiring hospital treatment for service-connected conditions in accordance with the foregoing instructions, only when hospitals under direct and exclusive jurisdiction of the Veterans Administration are not feasibly available, or when the urgency of the applicant's medical condition, the relative distance of the travel involved, or the nature of the treatment required in the individual case, make it necessary or economically advisable to utilize such other institutions instead of a hospital under direct and exclusive jurisdiction of the Veterans Administration. Other government hospitals under agreement will be used for hospitalization of beneficiaries requiring treatment for nonservice-connected disease or injuries only by those offices or hospitals to which the Administrator has given specific authority, and then only under the limitations defined in such authorization.

Except where prior approval of the medical director is required under the provisions of this paragraph, admissions to other government, private, state, or municipal hospitals may be authorized by chief medical officers or their designates in regional offices and hospitals with regional office activities, and by managers of insular offices.

Care of Women Veterans

(E) Women war veterans, needing treatment in a medical emergency for a condition either service-connected or not service-connected, may be authorized admission to a private hospital not under contract, if a government or private contract hospital is not feasibly available, without procurement of prior approval of the medical director. In these medically emergent cases the authority for admission to a private hospital not under contract will also be authority for payment of vouchers covering necessary services or supplies furnished in accordance with the stipulations specified in subparagraph (B) (1) hereof:

(1) Admission of a woman war veteran to a private hospital not under contract, for treatment of a disease or injury not service-connected when no medical emergency is existing, will not be authorized until prior approval of the medical director is secured.

(F) Managers of regional offices and hospitals having regional office activities, through chief medical officers or their designates, are empowered to authorize admissions to private hospitals, under contract, of women war veterans suffering from nonservice-connected diseases or injuries, as well as service-connected conditions, in a medical emergency or otherwise, without securing prior approval of the medical director; provided that a government hospital is not feasibly available; the condition of such beneficiary, if already so hospitalized, will not safely allow of her transfer to a government hospital; or the relative travel involved in admission to a government hospital, the medical condition existing, or the nature of the treatment required, make it advisable or economical to utilize the contract hospital.

(G) Pregnancy and childbirth will not entitle to hospitalization, either in hospitals under direct and exclusive jurisdiction of the Veterans Administration, or in other government, private, municipal or state hospitals.

Prior Approval Necessary

(H) The prior approval of the medical director must be secured for the use of private, state or municipal facilities covered by contracts, and located either within the continental limits of the United States or in the insular possessions or territories, for the hospitalization in such hospitals of beneficiaries in excess of the number of beds contracted for, except where immediate hospitalization is indicated for treatment of a medically emergent service-connected disease or injury. The number of beds set apart by agreements with other government hospitals, for treatment of Veterans Administration beneficiaries may be exceeded during any month as necessitated; provided that the utilization thereof be correspondingly reduced in other months, so that the average monthly use of such beds, at the end of the fiscal year, will not have exceeded the total allocation.

(I) An applicant whose eligibility for hospitalization, (whether for observation or treatment, or whether for a service-connected or nonservice-connected condition) had been determined, whose admission to a government hospital had been authorized and who had been supplied transportation therefor but who, while en route to the designated hospital (or en route from it, after completion of service and regular discharge, to the point from which he had proceeded to the hospital), develops an unavoidable and unforeseen medical emergency that forbids continuance of such travel and required admission to a private hospital or treatment by a private physician, will be entitled to such necessary services at the expense of the government, including any extra transportation costs (ambulance or otherwise) that were actually necessitated in the circumstances. (1) If the chief medical officer or his designate of the territory concerned is informed of such emergency hospital admission or such physician's treatment before or shortly after the beginning of services, authorization for the services, followed by payment of bills therefor, may be made in accordance with the terms of (B) (2). (2) If the chief medical officer or his designate had not authorized such hospitalization or such physician's service, he may nevertheless certify for payment bills from the hospital superintendent or the attending physician, provided determination is made of the actual necessity for the items of service rendered, and payment is at fees provided in the schedule of fees, Veterans Administration. (3) Subject to the same controlling conditions as in (2), the chief medical officer or his designate may authorize reimbursement of the beneficiary or his representative if either had paid bills submitted by the superintendent of the hospital or by the physician who had attended the beneficiary, and had submitted those receipted bills.

Hospitalization in Medical Emergency—Prior authority must always be obtained for travel incident to hospital treatment or domiciliary care. Ordinarily such authority will be issued when a veteran is notified of approval of his application, and transportation, meal and lodging requests, as necessitated, are sent to him or his representative. But when an applicant's condition is medically emergent authority for travel may be extended by telephone or telegraph subject to the procedure provided therefor.

On January 3, 1938, the National Foundation for Infantile Paralysis was established by the late President Roosevelt. With funds contributed by the American people through the annual March of Dimes, the Foundation today finances laboratory research in infantile paralysis in this country.

Research has sought answers to various questions, among them the following: the properties of the virus; the portal of entry; mechanisms of immunity; clinical aspects of the disease; inapparent infections; nerve-muscle interractions; treatment of after-effects.

A great amount of research has been done on the poliomyelitis virus. Scientists are now developing methods to study it by means of the newest device for high magnification, the electron microscope.

Neither ether, glycerine, nor sub-zero freezing destroy it. Dehydrated, the virus has been known to remain vigorous for three years.

Scientists seeking a drug to prevent or cure infantile paralysis have conducted more than 500 experiments using over 268 preparations, including the sulfa drugs and penicillin. Thus far, results have been negative.

Flies in epidemic areas are often found to be loaded with the virus, and the possible role of the mosquito in carrying the disease is being studied. Last summer extensive new tests were made. DDT was sprayed over certain epidemic areas to destroy all flies and mosquitoes, but it is still too early to judge the results.

In the eight years of its existence, the National Foundation has disbursed nearly $8,000,000 in grants for research and education.

In addition, many more millions have been spent by the National Foundation and its local chapters in nearly 3,000 counties in the United States for care and treatment of polio victims.

In spite of our humanitarian and best scientific efforts, polio remains today one of the most baffling problems of modern medicine.

Loans and Grants For Veteran Doctors*

IT IS probable that numerous Wisconsin physicians will want to make some use of the educational benefits available to them by reason of their military service. Many, no doubt, wish to continue studies in which they were engaged when activated into the armed services, and others will want to take refresher courses before resuming private practice. Some will use their educational entitlement in preparing for practice in one of the specialist fields. To all of these the Wisconsin program of veteran rehabilitation offers substantial assistance in the form of educational grants or loans together with economic grants and loans to assist them in the establishment or revival of their private practice.

Physicians recently released or about to be released from service may find it extremely difficult from a financial viewpoint to delay opening their offices for periods of several weeks or months. For many it would be utterly impossible, particularly the man with heavy family responsibilities, if his only income was the nominal subsistence allowance provided by either the G. I. Bill or Public Law 16, the vocational handicap bill.

The Wisconsin Board of Veterans Affairs, at a recent meeting, liberalized the educational grant policy of the department considerably, affording a new opportunity for further study to men who might otherwise be denied a chance to use their federal educational benefit. Applicants who are otherwise eligible, who are enrolled in courses of instruction under either federal Public Law 346 or 16, may now be awarded supplementary educational grants by the Wisconsin Department of Veterans Affairs depending on their circumstances and family situation. While the Wisconsin statute does not contemplate a bonus or annuity and specifies that grants may be made only to prevent or alleviate "want and distress," the law directs a liberal interpretation of this qualification, and the board has translated the legislative mandate into a realistic policy which guarantees sympathetic consideration for every application submitted.

Emergency grants are also available to the student for the benefit of himself or his dependents in unforeseen contingencies. The board recognizes that concern over his dependents' welfare may handicap the student veteran and has made liberal provision to cushion the shock of any emergent situation that might arise during the adjustment period.

Chapter 409, Wisconsin Laws of 1945, authorizes the Department of Veterans Affairs to make loans for education, rehabilitation, or the purchase of a property or business to veterans of World War II who meet the basic eligibility requirements of Wisconsin law. Thus the physician who needs new equipment for his office, an automobile to be used in his practice, or help in purchasing or improving a home, may borrow up to $750 at 2 per cent simple interest. Loans are amortized on a monthly basis, and the initial period on all loans is one year with the privilege of four renewals of one year each if commitments are met as they come due. The loan privilege may not be used as a refinancing facility unless the applicant's property is in jeopardy because of garnishment, attachment, etc. In the latter instance, loans may be made for the consolidation of debts. Loans made by the Department of Veterans Affairs must ordinarily be secured by mortgage, collateral, or acceptable endorsements. Character loans are made in certain special circumstances.

Veterans who have enrolled in school under the auspices of the federal Veterans Administration sometimes experience delay in receiving their first or succeeding federal subsistence checks. Loans will be made to these people on signature and are repayable upon receipt of the benefit for the period from the federal government. This repayment plan does not impose a hardship on the veteran because, though the initial federal check may be delayed, he ultimately receives a lump sum payment to bring his account up to date.

Loan applications should be filed through the County Veterans Service Office in the veteran's home county. The application will be reviewed by the local County Veterans Loan Committee and forwarded by the Committee to the Department of Veterans Affairs for disposition.

Beneficiaries of loans or grants under the Wisconsin law must retain their residence in the state during the period of receipt of benefits. Grants will not be made for educational courses in schools outside of the state if the same instruction is available within Wisconsin. This restriction does not, of course, apply to highly specialized courses, but a special determination will be made in each individual case based upon the recommendation of qualified advisers.

Basic eligibility requirements for benefits from the Postwar Rehabilitation Trust Fund administered by the Wisconsin Department of Veterans Affairs are:

1. The applicant must have been a bona fide resident of Wisconsin at the time of his enlistment or induction.
2. Must have served ninety days or more in the armed forces of the United States since August 27, 1940.
3. If service was less than ninety days, must have been discharged for service-incurred or aggravated disability.
4. Must have been honorably discharged or separated under honorable conditions.

* Prepared for the *Journal* by Leo B. Levenick, Director, Wisconsin Department of Veterans Affairs.

Members of the medical profession and others are invited to address the Director, Wisconsin Department of Veterans Affairs, State Capitol, Madison 2, Wisconsin, for further information. County veterans service officers, the service officers of veterans' organizations, and local chapters of the American Red Cross are also prepared to assist veterans with applications.

Recent Modifications of the G. I. Bill of Rights as They Relate to Medical Education

IN THE January, 1945, issue of *The Wisconsin Medical Journal* a complete exposition of the G. I. Bill of Rights, with special reference to needs of medical officers, was prepared by Mr. J. W. Holloway, Jr., Director of the Bureau of Legal Medicine and Legislation of the American Medical Association.* Since the publication of this article many changes have taken place to modify the provisions of the original bill, known as the Servicemen's Readjustment Act of 1944 (Public Law N. 346, Seventy-eighth Congress), and the information printed below is current at the time of publication but may be further modified by congressional action.

Loan Provisions: The loan provisions of the original law have been revised considerably in an effort to simplify the procedure by which a veteran can have guaranteed by the Veterans Administration 50 per cent of loans he negotiates for specified purposes, subject to the monetary limitation of $2,000 in the case of non-real-estate loans, or $4,000 in the case of real-estate loans. The detailed amendments are too complicated to reproduce in this brief outline, but physicians are reminded that money so borrowed can be used for the construction or alteration of business property or the purchase of equipment.

Educational Benefits: (1) *Eligibility:* Under terms of the original bill it was required that a veteran, over 25 years of age at the time of entry into service, show that his education was interrupted, impeded, delayed, or interfered with by entry into service. Since passage, this phase of the law has been modified so that each otherwise qualified veteran now will be entitled to one year of further education plus such additional time as he served on or after September 16, 1940, exclusive of any period he was assigned to the A. S. T. P. or Navy college training program.

(2) *Subsistence Allowance:* The subsistence allowance for a veteran without dependents has been increased from $50 to $65 a month and to a veteran with dependents from $75 to $90 a month.

(3) *Availability During Terminal Leave:* Certain benefits of the law relating to education and to loans are available to veteran officers while they are on terminal leave. The institution in which such a veteran undergoes training can be paid tuition fees during that period but the veteran will not be entitled to subsistence until after his discharge. However, such attending benefits as allowances for books, laboratory fees, and so forth, will be extended as soon as educational requirements are met, even though the schooling starts prior to final discharge.

(4) *Payments for Short Courses:* Under the original law if a veteran pursued a short, intensive course of less than 30 weeks' duration, the amount of federal funds that could be paid to the institution was prorated. If, for example, the course extended for a period of four weeks, the institution could be paid four-thirtieths of $500 only. This has been changed so that if the fees for the short refresher course of four weeks amount to, for example, $250, the institution can be paid the entire amount on behalf of the veteran but there will be charged against the veteran's period of eligibility the proportion of the ordinary school year which the cost of the course bears to $500, or, in other words, the veteran will have utilized one-half of a year of his period of eligibility.

Hospital Residencies: The provisions of the G. I. Bill of Rights pertaining to educational allowances have not covered adequately the needs of medical officers desiring hospital residencies or fellowships. Recent proposed changes, if adopted, will be published in the Journal of the American Medical Association and *The Wisconsin Medical Journal.* In general terms it can be said at the time of publication that the Veterans Administration has ruled that otherwise qualified physician veterans in residencies or fellowships are eligible for subsistence benefits and that the institution in which the residency or fellowship is served will be eligible for tuition remuneration, assuming that the institution has been approved in accordance with the provisions of the federal law.

Since passage of the original law efforts have been made to clarify the provisions covering subsistence allowances in cases of physicians receiving a stipend from the hospital he serves as a resident. On two occasions, the Director of Vocational Rehabilitation and Education Service of the Veterans Administration has indicated that there was nothing in the federal law that would preclude the receipt by the veteran of both the stipend and the subsistence allowance. Special reference is made to the Veterans Administration Instruction No. 2, dated January 18, 1945, page 8, paragraph (b) quoted on

* "The G. I. Bill of Rights," J. W. Holloway, Jr., *The Wisconsin Medical Journal,* January, 1945, pages 116–119.

page 527 of the June 16, 1945, Journal of the American Medical Association, which reads:

"Where the veteran is receiving compensation for productive labor, performed as part of his apprenticeship or other training on the job, the amount of subsistence when added to his current monthly salary or wage, based on the standard work week exclusive of overtime, shall not be in excess of the standard beginning salary or wage payable to a journeyman workman in the occupation or trade in which training is being given, similarly based on the standard work week exclusive of overtime."

While the above quotation does not have specific reference to professional employment it expresses a philosophy in keeping with the ruling of the Veterans Administration suggesting that both the hospital stipend and the subsistence allowance will be permitted in the case of physicians serving as residents.

The above brief notations of changes which have taken place in the G. I. Bill of Rights during the past year are presented with the understanding that further changes might be made during the ensuing year. When such changes are made they will be published in *The Wisconsin Medical Journal.* Details on loans or further interpretations of educational benefits as related to physicians can be secured by writing the Veterans Administration, 905 University Avenue, Madison, Wisconsin.

Bureau of Information, American Medical Association*

ESTABLISHMENT of the Bureau of Information on a permanent basis was one of the important actions taken by the House of Delegates of the American Medical Association at the annual session held in Chicago, December 3–5, 1945. The Council on Medical Service and Public Relations recommended to the House:

"The Bureau of Information of the American Medical Association should be established in a permanent form and maintain adequate records of each physician in the United States from which county and state medical societies could obtain information. The Bureau of Information should also, by the establishment of a co-operative monthly reporting system with state societies, be kept informed of areas needing physicians, and from time to time seek information either directly or through state medical societies from individual physicians concerning location, type of practice, and other relative data.

"Each state medical society should be urged to establish an information service. This state information service should collect from various public and private agencies data relating to medical facilities, medical personnel, or medical needs, and other information concerning medical care within the state. This information service should at all times be in a position to furnish information concerning areas in need of physicians and a complete picture of the medical facilities, physical and economic aspects of any community within the state.

"The American Medical Association should be urged to provide advice or service to such state information services relating to methods of organization and procedure, and aid the state services in developing a usefulness to the medical profession and to the people of their states."

The Reference Committee on Postwar Planning of the House of Delegates recommended approval of the foregoing recommendations made by the Council on Medical Service and Public Relations and specifically included in this report the following:

"Each state medical society should be urged to establish an information service. This state information service should collect from various public and private agencies data relating to medical facilities, medical personnel or medical needs, and other information concerning medical care within the state. This information service should at all times be in a position to furnish information concerning areas in need of physicians and a complete picture of the medical facilities, physical and economic aspects of any community within the state."

The report of the Reference Committee was adopted.

During the past year the main objective of the Bureau of Information has been to have at the central office up-to-date statistics of the medical facilities for each area in the country. At present, there is a permanent card file for the 3,072 counties in the United States, giving important data concerning the unit, the county—of these, there are still 525 counties which have not returned the completed summary sheets for their areas. Each card summarizes pertinent information about the economic and the medical practice aspects of the county. It includes population of the county; principal cities in the county and their population; nearest large centers; schools, including elementary, secondary, colleges, and universities; retail sales per capita per county and per state; resident telephones; miles of highways; dwelling units in the county; average monthly rentals; the location of the county; and its climate. Information important to medical practice includes the names and addresses of the president and secretary of the county medical society and the state medical society; the number and type of hospitals with the average bed capacity, average census, and the average number of births; notes on public health facilities and other medical installations and a list of physicians living in the community showing those in active practice, those in health departments, teaching positions, and other positions, and those retired. This list shows the number of doctors in each age group up to 65 years and the total number of doctors over 65 years of age. Since V-J day over 2,500 of these summaries have been transcribed at the request of the medical officers. Through the listings received from the state medical societies giving areas needing physicians and the many inquiries received each week from communities requesting the services of physicians, the Bureau has been able to keep an extensive file covering opportunities in gen-

* Prepared for the *Journal* by M. Virginia Shuler, Supervisor.

eral practice, the specialties, full-time salaried and industrial positions, practices and equipment for sale, and other varied fields of medical practice.

The plan of the Bureau of Information is to supply interested medical officers with information about areas in which they may desire to establish a practice. The Bureau is not a placement agency and does not in any way influence a physician in his choice of a location. When a returning medical officer expresses a desire for information about any particular locality he is sent a copy of the summary sheet for that area, and a letter is written referring him to the local state and county medical society for further assistance. Since many communities are holding vacancies open for men now in service, this liaison between the Bureau of Information and the county medical societies is necessary to provide accurate information of the needs of communities for physicians and to safeguard the practices of doctors still in service.

Since V-J day the Bureau of Information has had each week about 565 letters from medical officers and 110 physicians coming to the office for specific information regarding medical education, licensure, and re-location. Through the co-operation of the Council on Medical Education and Hospitals, the Bureau of Legal Medicine and Legislation, and the state medical societies, the Bureau has been able to give valuable information to the returning physicians to guide them in their adjustment to civilian life.

The Bureau's contacts with the returning physicians have been very gratifying since the medical officers are most appreciative of the effort the Bureau is making to be of service to them. One finds among the returning veterans a tendency to get away from the rush and tension of practice in large urban centers. The Bureau has helped some physicians, who before entering the armed services had well-established practices in large urban areas like Chicago, to re-locate in, as the physician terms it, "the wide open spaces." It is felt that through the co-operation of the smaller communities in attracting the physicians to their areas by offering them better hospital facilities, and an organized grouping of the physicians' services through health centers, there will be less difficulty in getting the physician seeking a place to re-establish his practice, to go into areas where he is most needed. Dr. F. S. Crockett, Chairman, Committee on Rural Medical Service, brought out in his report before the House of Delegates that the integration of the work of the Bureau of Information with the Committees of the Farm Bureau and other rural groups should go far in placing doctors, but that the placing of physicians cannot be considered as completing the job, and some way must be found to establish the facilities needed to keep them there. In order to bring informative data to every physician and to groups studying the medical care situation in the various states, it is the plan of the Bureau of Information, when the physicians who were in practice before entering the armed services have returned to their civilian practices again, to publish in the *Journal* periodically a map of the United States showing the physician population ratio for each county. Now, from time to time, the Bureau of Information publishes in the *Journal* certain data regarding the medical and economic aspects of certain areas.

Since several agencies of the Association, including the Committee on Postwar Medical Service, the Bureau of Information, the Council on Medical Education and Hospitals, and the Bureau of Legal Medicine and Legislation, have taken part in the gathering of information, a bulletin was designed to combine and abstract that information which would be most desired by medical officers, and to point out exactly how more specific and detailed data could be obtained. This Information Bulletin for Medical Officers was published by the American Medical Association and sent to every doctor in the armed services.

Your National Service Life Insurance

Its Provisions, Value, and Future Changes

ATTENDANT to military service the matter of insurance has been of concern to many Wisconsin physicians. Those holding National Service Life Insurance are often concerned with the advisability of retaining this type of insurance after return to civilian practice. For the benefit of all veteran members the 1946 Blue Book issue of the *Journal* includes a review of National Service Life Insurance as published in the 1945 Blue Book issue (pages 126–129), as well as statements more recently published in "New York Medicine" in reference to this subject.

NATIONAL SERVICE LIFE INSURANCE

Introduction

To provide life insurance in amounts from $1,000 to $10,000 for persons in the active service of the armed forces of the United States there was enacted four years ago a statute known as the "National Service Life Insurance Act of 1940." This was enacted in anticipation of the perils incident to service in our armed forces either under the Selective Service Act or during a state of actual war, it being appreciated it would be impossible for men in service to procure adequate life insurance from private

carriers except at extremely high rates. An outstanding difference between the War Risk Insurance Act of 1917 and the 1940 act is that the former provides for benefit payments in the event of total and permanent disability, as well as in the case of death, whereas the recent act does not. The 1940 act provides only for life insurance. However, it does provide that payment of premiums is waived during the continued total disability of a service man which began subsequent to the effective date of his insurance, and which continued for six consecutive months or more prior to the insured's sixtieth birthday.

A 1941 amendment provides automatic insurance, if no government insurance had been in force, against death in line of duty in active service in an aggregate amount of $5,000 where such death occurred between October 8, 1940, and April 19, 1942. A 1942 amendment goes even farther by providing in the case of men in service who have in fact not applied for insurance, that $5,000 shall be deemed to be in force, with waiver of premium, during a period of total disability as a result of injury or disease incurred in line of duty, where such disability continues without interruption for six months, such premium waiver to continue until six months after total disability ceases, so long as such date is not later than April 21, 1943.

A second 1942 amendment places in force $5,000 in insurance on those who did not have that much in force under the National Service Life Insurance Act, or under the prior acts of 1917, or 1924, in all cases of men subjected to capture, siege, or isolation between December 7, 1941, April 20, 1942. Premiums on such insurance shall be waived during the period that such insured person remains captive, besieged, or isolated, and for six months thereafter. The humanitarian purpose and intent of these amendments are self evident.

Persons Insurable

Any person in active service in the land or naval services of the United States, including the Coast Guard, is entitled to apply for national life insurance if such person is serving under orders to active duty not limited to a period of less than thirty-one days.

Any person in active service on December 20, 1941, could apply for insurance without the requirement of a medical examination up to April 19, 1942, but after that date would have to pass a medical examination. Persons entering active service after December 20, 1941, have 120 days within which to apply for national service life insurance without medical examination.

It is strongly urged that a physician apply for insurance as soon as he enters upon active duty. It is uncertain whether he has a right to increase or decrease the amount of insurance originally asked for, as the act is silent on this question. However, there are known instances where increases have been allowed, but this is not true of decreases. The insurance becomes effective upon the date specified in the application but not later than the first day of the calendar month following the date of application.

It is prudent to have the insurance take effect immediately since the government is not liable in the case of death which intervenes between the date of application and the date the insurance was to take effect, if those dates are not the same. Thus, if a physician applied for insurance on October 1 to be effective November 1, and died October 15, there would be no liability on the part of the government. If, however, he had applied September 1 and had stipulated that the insurance take effect as of that day, the government would be liable were his death to occur on September 15.

Beneficiaries

If no beneficiary is designated in the policy, the proceeds are payable in the following order to the following person or group surviving the deceased insured: widow, child or children, parent or parents, brothers and sisters. If none of the above persons or groups survive, the government will make no payment. The insurance is not payable to the estate of the insured person in such a situation as was true under the 1917 act.

If the insured person desires to designate a beneficiary, he is limited to the above classes and to stepchildren, to illegitimate children, and to relatives or others who have given him a home or otherwise taken the place of natural parents.

It is uncertain whether insurance under the 1940 act is payable to an adopted child or to adopted brothers and sisters, stepbrothers and stepsisters, and sisters and brothers of the half-blood. Under a 1942 amendment a father or mother by adoption may expressly be included as a beneficiary. The information booklet issued by the Veterans Administration, dated August, 1941, and designated as "Insurance Form 398," states that an adopted child may be a beneficiary. While this is a desirable administrative ruling, it is not certain that the courts will so hold under the wording of the act.

The service man carrying national service life insurance has the right at all times to change the beneficiary or beneficiaries without the consent of the latter. Under the act the beneficiary has no vested or property rights in the proceeds of the insurance, even under a contract whereby the insured agrees not to change the beneficiary.

Cost and Conversion of Service Insurance

The cost of national service life insurance varies between 67 cents per month per $1,000 for a man of twenty-four and $1.27 per month per $1,000 for a man of fifty. Since a physician going into service will seldom be less than twenty-four, and few of them will be more than fifty these examples of monthly costs should suffice to indicate the range. The rates rise rather rapidly for men over fifty.

This service insurance is five year, level premium, term insurance, without any cash value during the term period. The privilege of conversion to policies

of national service life insurance on ordinary life, twenty payment life, or thirty payment life plan is permitted any time between the end of the first and prior to the expiration of the fifth year of the term. Unless converted on or before expiration of the five year term period, the insurance ceases and terminates on the latter date. The ordinary life policy will be payable throughout the lifetime of the insured, as is true of insurance with private companies. A twenty payment life contract pays up the policy after twenty years, and a thirty payment life contract does likewise after thirty years.

Payment of Benefits

The proceeds of a national service life insurance policy are not paid or payable in their face amount at the time of the death of the assured but are distributed in equal monthly installments over a period of ten or twenty years according to the age of the beneficiary. If the beneficiary to whom payment is first made is under thirty years of age at the time of death of the insured, payment shall be made over a twenty year period in 240 equal monthly installments at the rate of $5.51 for each $1,000 of insurance.

If the beneficiary to whom payment is first made is thirty or more years of age at the date of death of the insured, payment is made over a ten year period in 120 equal monthly installments in accordance with a schedule based upon the American experience table of mortality, with interest at 3 per cent. The amounts so paid vary from $3.97 a month per $1,000 of insurance in the case of a beneficiary thirty years of age, to $9.61 per $1,000 per month in the case of a beneficiary eighty-five years of age.

Upon proof of death of the first beneficiary, monthly installments shall thereafter be made in the same amount to the person or persons next entitled to receive the proceeds, until all of the installments shall have been paid. Neither the statute nor the regulations thus far disclose what is to be done if there are two or more persons in one class, one of whom is under thirty and one over thirty, when the first monthly installment is paid, but this will be worked out in time.

To Hold, Convert, or Drop?

In the November 20, 1945, issue of "New York Medicine" a short article on National Service Life Insurance was directed to physicians who might come in contact with servicemen who questioned the advisability of continuing their payments of premiums. The advice is likewise applicable to physicians themselves. We quote:

"1. National Service Life Insurance is a participating contract with a lower gross premium than issued by private companies.

2. There is no loading for expense of administration, acquisition, etc., since this charge is borne by the taxpayers.

3. Conversion may be exercised without evidence of insurability.

4. Non-forfeiture provisions are higher than private companies since the contract does not contain a surrender charge.

5. Waiver of premium benefits is included without extra charge and the phraseology of this clause is much more liberal than will be found in private company contracts. Also, the interpretation of this clause is more liberal.

6. The contract contains no restrictions as to residence, travel, aviation or war.

7. Proceeds are completely tax free and creditor proof.

In July, 1945, National Service Life Insurance was extended to December 31, 1948. This has caused a great deal of confusion among returning veterans. While the contract is written on a five year level premium term basis, all veterans now have until December 31, 1948 to exercise their conversion privilege and will continue to pay the premium on the original five year term basis until conversion.

It is of the utmost importance to urge the veteran to continue to send his premium to the Collection Sub-Division, Veterans' Administration, Washington, D. C. by check, draft or money order, payable to the Treasurer of the United States, even though he does not hear from the Administration. The fact that he may not receive a premium receipt or premium notice does not relieve him of the responsibility of keeping his insurance in force by remitting his check.

Regarding the known disadvantages, at the moment, of National Service Life Insurance, it is reasonable to expect that proper legislation will be passed in the very near future to correct, liberalize and improve the benefits under National Service Life Insurance on behalf of the serviceman and his dependents."

FIRST-AID CARE

The question of first-aid facilities is one of increasing importance particularly in concerns employing a substantial number. First-aid should be rendered by the physician whenever possible, and where this is not possible a physician should be obtained without delay so that first-aid measures may be conducted under his supervision. This subject was covered in a bulletin republished by the State Medical Society of Wisconsin in 1941 under the title "Suggestions for the Guidance of the Nurse in Industry."

RULES AND PROCEDURES COVERING

EMERGENCY MEDICAL CARE AND HOSPITALIZATION

of World War II Veterans and Their Dependents in the State of Wisconsin

1. WHAT IS THE DEPARTMENT OF VETERAN AFFAIRS, STATE OF WISCONSIN?

Through direct legislative appropriation the Department of Veterans Affairs has been established to assist, through financial means, *Wisconsin* residents who have served in World War II, who for one reason or another do not qualify for care needed under the administration of the Veterans Administration or elsewhere.

The Veterans Administration is a *federal* agency, serving all honorably discharged veterans, irrespective of residency and is prepared to render medical and hospital assistance under certain rules and procedures.

The Wisconsin Department of Veterans Affairs, is a *state* agency, established to assist veterans of World War II and their dependents who are residents of the state and are unable to secure assistance through the Veterans Administration or elsewhere with the dispatch necessary to meet their needs.

2. WHO IS A WORLD WAR II VETERAN QUALIFIED FOR STATE ASSISTANCE IN WISCONSIN?

A. Any male or female who was a resident of the State of Wisconsin at the time of entering military service is considered a World War II Veteran, and for state assistance in medical care or hospitalization he or she must present evidence:

(1) Of having been in service at least ninety days between August 27, 1940, and the end of World War II.

(2) If having been in service less than ninety days, being honorably discharged for a service-incurred disability.

3. UNDER WHAT CIRCUMSTANCE MAY A WORLD WAR II VETERAN SECURE ASSISTANCE IN THE FORM OF MEDICAL CARE THROUGH THE WISCONSIN DEPARTMENT OF VETERANS AFFAIRS?

The Wisconsin Department of Veterans Affairs is prepared to cover cost of medical care rendered to World War Veterans II and dependents under the following specific conditions:

(A) *Residence Requirements:* Only those who were (1) residents of Wisconsin at the time of entering military service or (2) residents of Wisconsin for five years prior to application for assistance *even though non-residents of Wisconsin at time of entering service,* can apply for aid through the Wisconsin Department of Veterans Affairs.

(B) *Emergency and Want:* Even though a veteran may have residence requirements outlined in "A" above, he must establish the fact that the care is of an emergency nature, and that his case is one of actual want or distress, present or imminent.

The physician is required to certify that the case is of an emergency character and the veteran has the responsibility of establishing the claim of want or distress, through certification of the county veterans service officer, Red Cross, or other responsible agencies.

* *

YOU AS A PHYSICIAN WILL BE REQUIRED TO DETERMINE ONLY THE EMERGENCY CHARACTER OF THE CASE.

4. CANNOT SUCH CASES BE HANDLED BY THE VETERANS ADMINISTRATION?

The Veterans Administration is required to handle all service-connected disability cases, so if your preliminary contact establishes this fact the case is a responsibility of the Veterans Administration. An example of "service-connected disability" would be recurrent malaria *if the original source of the illness had been experienced when the veteran was in service.* The County Veteran Service Officer should have the veteran apply to Veterans Administration at Wood, Wisconsin or Minneapolis, Minnesota for hospitalization. The Veterans Administration must be notified *within twenty-four hours* in a case of service-connected disability.

However, all other cases which have no direct connection with service disability, or cannot be handled by the Veterans Administration in accordance with medical needs, due to lack of available facilities, must either be handled independently by the veteran or be covered by the Wisconsin Department of Veterans Affairs, if of an *emergency*

character and want or distress are factors, and so long as the veteran meets the residence, service, and discharge requirements noted above.

5. ARE DEPENDENTS COVERED?

Yes, as long as the veteran's residence and requirements of emergency and want and distress are established. This includes obstetrics, pediatrics, and surgery as well as hospitalization.

6. IN CASE OF HOSPITALIZATION MUST THE VETERAN OF HIS DEPENDENT BE CARED FOR IN A SPECIFIED HOSPITAL?

No. Any accredited hospital or any licensed physician will be recognized for payments, as long as applications are received and approved by the Wisconsin Department of Veterans Affairs, Madison, within seventy-two hours of admission.

7. WHO CAN BE CONSULTED TO ASSIST IN ESTABLISHING CLAIMS OF WANT OR DISTRESS?

Each county has a Veterans Service Officer, usually located at the county seat. Consult the roster given on page four and feel free to call on the officer in your county or the officer closest to your community for consultation and necessary forms and assistance.

8. WHAT FEES WILL BE ALLOWED?

As the cases covered by the Wisconsin Department of Veterans Affairs are those of the low income group the fees established in "The Wisconsin Plan" will be used as a guide for payment. In the case of hospitalization for obstetrics a modified Emergency Maternal and Infant Care schedule approved by the Wisconsin Hospital Association will be used.

9. WHAT PROCEDURES MUST BE FOLLOWED TO ESTABLISH CLAIMS AND SECURE PAYMENT?

A. The first step is to establish qualifications on the basis of military service, residency, and character of service (emergency, want, and distress if carried independently). The basic information required is given on the form reproduced below.

B. *Within seventy-two hours* after request for medical care or hospitalization the initial Application Form must be filed with the Wisconsin Department of Veterans Affairs, State Capitol, Madison, Wisconsin.

C. Upon receipt of authorization from the Wisconsin Department of Veterans Affairs the required medical report must be filled out in duplicate, with the original returned to the Wisconsin Department of Veterans Affairs and the duplicate retained in your files.

D. The final medical report must be submitted to the Wisconsin Department of Veterans Affairs before payment will be authorized.

EMERGENCY CARE ONLY

On the following page is a copy of the form to be used in the reporting of medical cases involving *emergency* care given veterans of World War II and their dependents, applying for financial assistance through the Wisconsin Department of Veterans Affairs.

In handling medical cases involving veterans of World War II it is important to note that financial assistance through the Wisconsin Department of Veterans Affairs can only be secured on the basis of (1) emergency medical care, and (2) want or distress. The physician is not required to certify the feature of want or distress, though if it is known that the patient has financial means to handle the payments without assistance it will aid the Wisconsin Department of Veterans Affairs to refrain from filing a report form. However, from the viewpoint of the attending physician the important point to bear in mind is that the case *must be of an EMERGENCY character* to meet the qualifications for aid.

Copies of the report form given on the following page have been supplied all physicians. Extra copies can be secured by writing the Wisconsin Department of Veterans Affairs, State Capitol, Madison 2.

DVA-No. 45 (Rev.)
1-10-46–20M

This form must be filed with the WISCONSIN DEPARTMENT OF VETERANS AFFAIRS, State Capitol, Madison 2, *within 72 hours* after first consultation with the patient.

NOTICE OF EMERGENCY TREATMENT

Restricted to Veterans of World War II or Their Dependents

1. Patient's Name: _____

2. Address _____ Veteran? _____

3. If a dependent, give veteran's name and relationship: _____

4. Address of Veteran _____

5. Veteran's service data: Service Serial Number _____

   When Inducted _____ Where Inducted _____

   When Discharged _____ Where Discharged _____

6. EMERGENCY Medical Care Data:

   Date care first requested: _____ Nature of Emergency Medical Care:

   _____

   _____

   Why medical care classified as emergency? _____

Was patient hospitalized? _____ If so, name and location of hospital. _____

_____

Date first hospitalized _____ Probable duration _____

NOTICE: Care will *not* be provided at the expense of the Wisconsin State Department of Veterans Affairs *unless* this is an emergency case, *and* unless it is to prevent actual or probable want or distress. The physician certifies *the emergency character* of need; the veteran *must* establish financial want or distress through the county veterans service officer, Red Cross, or similar agency.

Signature of Veteran _____

Signature of Kin if Veteran unable to Sign _____

Signature of Physician _____

Address of Physician _____

STATE OF WISCONSIN

No. 53, A, 1943.

A JOINT RESOLUTION

Urging physicians and dentists to maintain records of services rendered to veterans of the present war.

WHEREAS, It is essential to the recovery of federal war compensation by veterans of the present war that a given disability be shown to have resulted from and in connection with the military service of the claimant, and

WHEREAS, It is also essential to proof of such service-connected disability that all treatment records kept by a physician or dentist of the claimant be available to military and federal authorities, and the absence of such a record may defeat the bona fide claim of a veteran; now, therefore, be it

Resolved by the assembly, the senate concurring, That the state board of health, state board of medical examiners, the state board of dental examiners, and the several professional societies be requested forthwith to ask that all practicing physicians and dentists ascertain, so far as possible, whether patients are now or are on any subsequent date veterans of the present war, and that in the case of each such veteran his case history be preserved for at least 6 years after the date the last professional service is rendered by such physician or dentist. Be it further

Resolved, That each of the above boards and professional societies be further requested to contact all of their respective licensees and members at least once a year for the balance of the war, and at least once each year for the first 6 years following the war, so as to remind all such persons of the importance to the war veterans of preserving such professional records; and be it further

Resolved, That duly attested copies of this resolution be transmitted forthwith to such boards and professional organizations.

Conrad Shearer — PRESIDENT PRO TEMPORE OF THE SENATE.

Vernon W. Thomson — SPEAKER OF THE ASSEMBLY.

Lawrence R. Larsen — CHIEF CLERK OF THE SENATE.

Arthur L. May — CHIEF CLERK OF THE ASSEMBLY.

This resolution was introduced by Assemblyman Lyall T. Beggs, of Dane County, a veteran of the first World War and Past Vice-Commander of the American Legion. It will be printed periodically in *The Wisconsin Medical Journal* during the next several years.

Officers and Committees, 1946, State Medical Society of Wisconsin

President

Dr. P. R. Minahan
110 North Washington Street
Green Bay

President-Elect

Dr. C. A. Dawson
River Falls

Secretary

Mr. C. H. Crownhart
917 Tenney Building
Madison 3

Assistant Secretary

Mr. Roy T. Ragatz
917 Tenney Building
Madison 3

Treasurer

Dr. I. R. Sisk
1 South Pinckney Street
Madison 3

Speaker, House of Delegates

Dr. E. C. Cary
Reedsville

Vice-Speaker

Dr. L. O. Simenstad
Osceola

Councilors*

(Dr. S. E. Gavin, Fond du Lac, Chairman)

First: Dodge, Jefferson and Waukesha County Societies. Dr. J. F. Wilkinson, Oconomowoc, 1948.

Second: Kenosha, Racine and Walworth County Societies. Dr. C. E. Pechous, 625 Fifty-seventh Street, Kenosha, 1948.

Third: Dane, Columbia–Marquette–Adams, Green, Rock and Sauk County Societies, Dr. C. O. Vingom, 122 West Washington Avenue, Madison 3, 1946.

Fourth: Crawford, Grant, Iowa, Lafayette and Richland County Societies. Dr. E. H. Spiegelberg, Boscobel, 1946.

Fifth: Calumet, Manitowoc, Sheboygan and Washington–Ozaukee County Societies. Dr. A. H. Heidner, West Bend, 1946.

Sixth: Brown–Kewaunee–Door, Fond du Lac, Outagamie and Winnebago County Societies. Dr. S. E. Gavin (chairman), 104 South Main Street, Fond du Lac, 1946.

Seventh: Juneau, La Crosse, Monroe, Trempealeau–Jackson–Buffalo and Vernon County Societies. Dr. S. D. Beebe, Sparta, 1947.

Eighth: Marinette–Florence, Oconto and Shawano County Societies. Dr. A. T. Nadeau, Marinette, 1947.

Ninth: Clark, Green Lake–Waushara, Lincoln, Marathon, Portage, Waupaca and Wood County Socities. Dr. H. H. Christofferson, Colby, 1947.

Tenth: Barron–Washburn–Sawyer–Burnett, Chippewa, Eau Claire–Dunn–Pepin, Pierce–St. Croix, Polk and Rusk County Societies. Dr. R. G. Arveson, Frederic, 1947.

Eleventh: Ashland–Bayfield–Iron and Douglas County Societies. Dr. V. E. Ekblad, 1507 Tower Avenue, Superior, 1948.

Twelfth: The Medical Society of Milwaukee County. Dr. Robert W. Blumenthal, 411 East Mason Street, Milwaukee 2, 1946; Dr. R. E. Fitzgerald, 2750 North Teutonia Avenue, Milwaukee 6, 1948; Dr. D. H. Witte, 3405 West Lisbon Avenue, Milwaukee, 1948.

Thirteenth: Forest, Langlade, Oneida–Vilas and Price–Taylor County Societies. Dr. J. D. Leahy, Park Falls, 1947.

Dr. Charles Fidler (Past-President), 231 West Wisconsin Avenue, Milwaukee, 1946.

Delegates to American Medical Association

Dr. S. E. Gavin (1946)
104 South Main Street
Fond du Lac

Dr. J. C. Sargent (1946)
324 East Wisconsin Avenue
Milwaukee 2

Dr. W. D. Stovall (1947)
Service Memorial Institute
Madison 6

Alternates

Dr. L. O. Simenstad (1946)
Osceola

Dr. E. J. Carey (1946)
561 North Fifteenth Street
Milwaukee

Dr. D. J. Twohig (1947)
Fond du Lac

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* Map indicating location of councilor districts, page 121.

W. S. BUMP
Chairman, Committee on Cancer

ARNOLD S. JACKSON
Chairman, Committee on Goiter

C. O. VINGOM
Chairman, Committee on Coordination of Medical Services

H. A. SINCOCK
Chairman, Advisory Committee on Care of Crippled Children

Standing Committees

The Committee on Cancer

Dr. W. S. Bump, 1947, chairman, Rhinelander

Dr. L. J. Van Hecke, 1947, 231 West Wisconsin Avenue, Milwaukee 3

Dr. A. L. Mayfield, 1947, 625 Fifty-seventh Street, Kenosha

Dr. H. H. Kleinpell, 1947, Prairie du Chien

Dr. J. C. Fox, 1947, 401 Main Street, La Crosse

Dr. Julius Blom, 1947, 314 East Grand Avenue, Eau Claire

Dr. J. W. McGill, 1948, 1225 Tower Avenue, Superior

Dr. A. R. Curreri, 1946, 1300 University Avenue, Madison 6

Dr. G. E. Eck, 1948, Lake Mills (In service)

Dr. J. D. Wilkinson, 1948, Oconomowoc (Alternate for Dr. Eck)

Dr. D. J. Twohig, 1948, 11 North Main Street, Fond du Lac

Dr. L. W. Peterson, 1946, Shawano

Dr. G. L. McCormick, 1946, Marshfield

Dr. C. J. Weber, 1948, Sheboygan

The Advisory Committee on Care of Crippled Children

Dr. H. A. Sincock, 1948, chairman, 1507 Tower Avenue, Superior

Dr. J. B. MacLaren, 1947, 120 South Oneida Street, Appleton

Dr. H. L. Greene, 1947, 1 South Pinckney Street, Madison 3

Dr. W. P. Blount, 1946, 324 East Wisconsin Avenue, Milwaukee 2

Dr. T. L. Squier, 1946, 425 East Wisconsin Avenue, Milwaukee 2

Dr. C. M. Kurtz, 1948, 1300 University Avenue, Madison 6

The Committee on Coordination of Medical Services

Dr. C. O. Vingom, 1947, chairman, 122 West Washington Avenue, Madison 3

Dr. J. W. Prentice, 1946, 522 Second Street, Ashland

Dr. S. E. Gavin, 1948, 104 South Main Street, Fond du Lac

President, ex officio

Secretary, ex officio

The Committee on Goiter

Dr. Arnold S. Jackson, 1948, chairman, 16 South Henry Street, Madison 3

Dr. E. W. Schacht, 1946, 423 Main Street, Racine

Dr. Millard Tufts, 1947, 208 East Wisconsin Avenue, Milwaukee 2

Dr. E. L. Sevringhaus, ex officio, 1300 University Avenue, Madison 6

Dr. C. N. Neupert, ex officio, State Office Building, Madison 2

The Committee on Grievances

Dr. W. W. Kelly, 1946, chairman, 122 East Walnut Street, Green Bay

Dr. W. A. Ryan, 1947, Milwaukee (In service)

W. W. KELLY
Chairman, Committee on Grievances

NORBERT ENZER
Chairman, Committee on Health and Public Instruction

W. E. GROVE
Chairman, Committee on Hearing Defects

J. E. HABBE
Chairman, Committee on Hospital Relations

Dr. E. J. Schneller, 1947, 744 Main Street, Racine (Alternate to Doctor Ryan)

Dr. A. G. Sullivan, 1948, 16 North Carroll Street, Madison 3

The Committee on Health and Public Instruction

Dr. Norbert Enzer, 1946, chairman, 425 East Wisconsin Avenue, Milwaukee 2

Dr. C. J. Newcomb, 1947, 411 East Mason Street, Milwaukee 2 (In service)

Dr. L. H. Lokvam, 1947, 723—Fifty-eighth Street, Kenosha (Alternate to Dr. Newcomb)

Dr. L. R. Cole, 1948, 1300 University Avenue, Madison 6

The Committee on Hearing Defects

Dr. W. E. Grove, 1946, chairman, 324 East Wisconsin Avenue, Milwaukee 2

Dr. A. E. Rector, 1947, 103 West College Avenue, Appleton

Dr. T. L. Tolan, 1948, 324 East Wisconsin Avenue, Milwaukee 2

The Committee on Hospital Relations

Dr. J. E. Habbe, 1948, chairman, 231 West Wisconsin Avenue, Milwaukee 3

Dr. A. J. McCarey, 1948, 305 East Walnut Street, Green Bay

Dr. R. M. Waters, 1947, 1300 University Avenue, Madison 6

Dr. M. L. Jones, 1946, 510½ Third Street, Wausau

Dr. E. O. Gertenbach, 1946, 425 East Wisconsin Avenue, Milwaukee 2

Dr. E. L. Tharinger, 1947, 231 West Wisconsin Avenue, Milwaukee 3

The Committee on Industrial Health

Dr. D. E. Dorchester, 1948, chairman, Sturgeon Bay

Dr. M. J. Reuter, 1946, 324 East Wisconsin Avenue, Milwaukee 2

Dr. T. J. Howard, 1947, 716 North Eleventh Street, Milwaukee 3

Dr. L. W. Hipke, ex officio, 425 East Wisconsin Avenue, Milwaukee 2

The Committee on Maternal and Child Welfare

Dr. W. C. Stewart, 1946, chairman, 5825 Sixth Avenue, Kenosha

Dr. R. W. Rice, 1948, Stevens Point

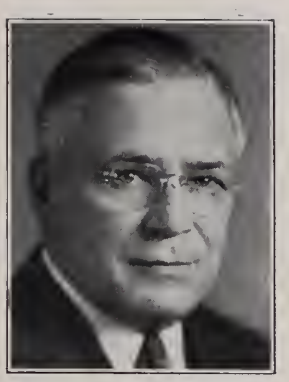
Dr. J. W. Harris, 1948, 1300 University Avenue, Madison 6

Dr. Robert F. Purtell, 1947, 758 North Twenty-seventh Street, Milwaukee

D. E. DORCHESTER
Chairman, Committee on Industrial Health

W. C. STEWART
Chairman, Committee on Maternal and Child Welfare

F. D. MURPHY
Chairman, Committee on Medical Education and Hospitals



R. G. ARVESON
Chairman, Council on Medical and Public Relations

H. H. CHRISTOFFERSON
Chairman, Committee on Mental Hygiene and Institutional Care

Dr. Amy Louise Hunter, 1947, State Office Building, Madison 2

Dr. W. A. Wagner, 1946, 130 Main Street, Oshkosh

The Committee on Medical Economics and Voluntary Sickness Insurance

Dr. Robert Krohn, 1946, chairman, Black River Falls

Dr. L. D. Quigley, 1947, 207 East Walnut Street, Green Bay

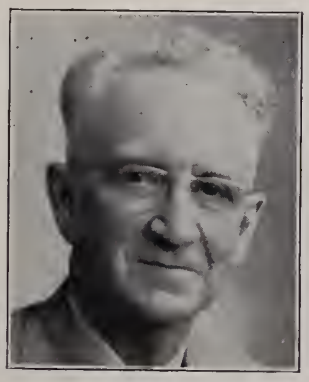
Dr. T. A. Leonard, 1947, 110 East Main Street, Madison 3 (In service)

Dr. J. S. Supernaw, 1947, 110 East Main Street, Madison 3 (Alternate for Dr. Leonard)

Dr. J. E. Habbe, 1946, 231 West Wisconsin Avenue, Milwaukee 3

Dr. H. B. Norviel, 1948, Phillips

Dr. L. J. Bayer, 1948, Merrill



C. A. DAWSON
Chairman, Committee on Public Policy

The Committee on Medical Education and Hospitals

Dr. F. D. Murphy, 1948, chairman, 536 West Wisconsin Avenue, Milwaukee 3

Dr. P. A. Midelfart, 1947, 314 East Grand Avenue, Eau Claire (In service)

Dr. C. R. Marquardt, 1946, 324 East Wisconsin Avenue, Milwaukee 2

Council on Medical and Public Relations

Dr. R. G. Arveson, 1946, chairman, Frederic

Dr. A. E. Rector, 1946, 103 West College Avenue, Appleton

Dr. J. S. Supernaw, 1946, 110 East Main Street, Madison

Dr. R. P. Montgomery, 1946, 324 East Wisconsin Avenue, Milwaukee

Dr. C. R. Marquardt, 1946, 324 East Wisconsin Avenue, Milwaukee

President, ex-officio

Past-president, ex-officio

Chairman of the Council, ex-officio

Speaker of the House of Delegates, ex-officio

The Committee on Mental Hygiene and Institutional Care

Dr. H. H. Christofferson, 1947, chairman, Colby

Dr. B. J. Hughes, 1948, Winnebago

Dr. A. W. Bryan, 1946, 16 South Henry Street, Madison 3

The Committee on Public Policy

Dr. C. A. Dawson, 1948, chairman, River Falls

Dr. S. E. Gavin, 1947, 104 South Main Street, Fond du Lac

H. J. GRAMLING
Chairman, Committee on Rural Health and Accident Prevention

C. D. NEIDHOLD
Chairman, Council on Scientific Work

L. O. SIMENSTAD
Chairman, Committee on Tuberculosis and Chest Diseases

J. K. TRUMBO
Chairman, Committee on Visual Defects

Dr. E. C. Cary, 1946, Reedsville
President ex-officio
President-elect, ex-officio
Secretary, ex-officio

The Committee on Rural Health and Accident Prevention

Dr. H. J. Gramling, 1947, chairman, 2740 West Forest Home Avenue, Milwaukee
Dr. R. L. MacCornack, 1946, Whitehall
Dr. N. M. Kersten, 1948, De Pere

The Council on Scientific Work (Five-Year Memberships)

Dr. C. D. Neidhold, 1947, chairman, 103 West College Avenue, Appleton
Dr. F. D. Murphy, 1946, 536 West Wisconsin Avenue, Milwaukee
Dr. E. R. Schmidt, 1949, 1300 University Avenue, Madison 6
Dr. C. F. Midelfort, 1948, 1836 South Avenue, La Crosse
Dr. J. M. Freeman, 1950, Wausau
Dr. K. H. Doege, ex-officio, Marshfield
Dr. W. S. Middleton, ex-officio, 1300 University Avenue, Madison 6
Dr. E. J. Carey, ex-officio, 561 North Fifteenth Street, Milwaukee 3

The Committee on Tuberculosis and Chest Diseases

Dr. L. O. Simenstad, 1946, chairman, Osceola
Dr. A. V. Cadden, 1947, Muirdale Sanatorium, Milwaukee 13
Dr. A. A. Pleyte, 1948, 1018 North Jefferson Street, Milwaukee 2

The Committee on Visual Defects

Dr. J. K. Trumbo, 1947, Chairman, 502 Third Street, Wausau
Dr. R. P. Sproule, 1946, 208 East Wisconsin Avenue, Milwaukee 2
Dr. A. H. Pember, 1948, 500 West Milwaukee Street, Janesville

The Advisory Committee to Woman's Auxiliary

Chairman of Council, chairman
Immediate past-president
President
President-elect
Secretary

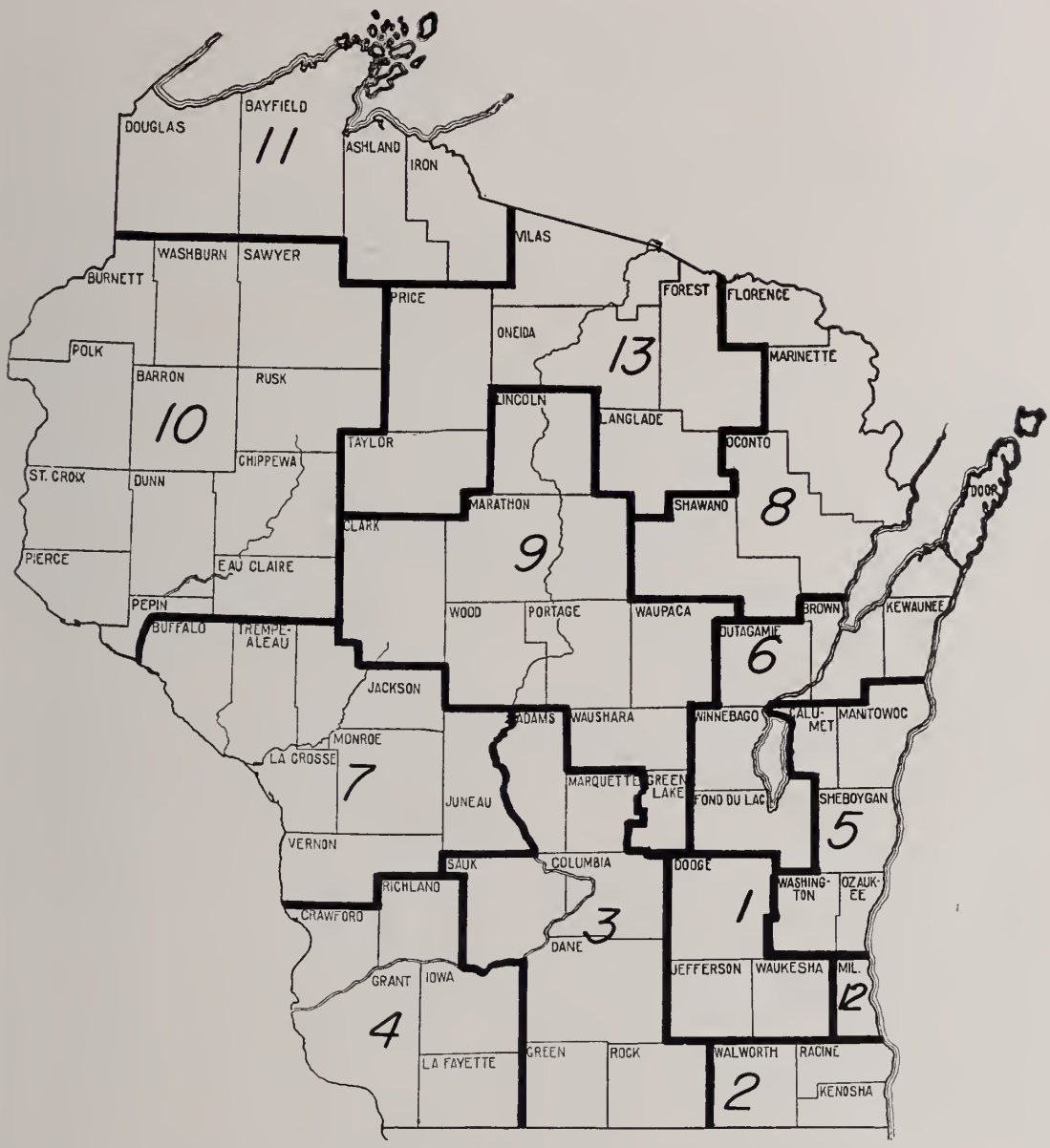
COMMITTEE OF THE PRESIDENT

The Special Committee Advisory to the Department of Public Welfare

Dr. W. A. Munn, chairman, 19 South Main Street, Janesville
Dr. H. K. Tenney, 1 South Pinckney Street, Madison 3
Dr. H. L. Greene, 1 South Pinckney Street, Madison 3
Dr. E. W. Mason, 324 East Wisconsin Avenue, Milwaukee 2
Dr. J. L. Garvey, 208 East Wisconsin Avenue, Milwaukee 2

COMMITTEES OF THE COUNCIL

(The personnel of these committees will be appointed by the chairman of the Council at the January Council meeting and will be found in the minutes of that meeting, to be published in the March *Journal.*)



MAP INDICATING LOCATION OF COUNCILOR DISTRICTS

First District:
Dr. J. F. Wilkinson, Oconomowoc

Second District:
Dr. C. E. Pechous, Kenosha

Third District:
Dr. C. O. Vingom, Madison

Fourth District:
Dr. E. H. Spiegelberg, Boscobel

Fifth District:
Dr. A. H. Heidner, West Bend

Sixth District:
Dr. S. E. Gavin, Chairman
Fond du Lac

Seventh District:
Dr. S. D. Beebe, Sparta

Eighth District:
Dr. A. T. Nadeau, Marinette

Ninth District:
Dr. H. H. Christofferson, Colby

Tenth District:
Dr. R. G. Arveson, Frederic

Eleventh District:
Dr. V. E. Ekblad, Superior

Twelfth District:
Dr. D. H. Witte, Milwaukee
Dr. R. E. Fitzgerald, Milwaukee
Dr. Robert W. Blumenthal, Milwaukee

Thirteenth District:
Dr. J. D. Leahy, Park Falls

Charter Law of Medical Societies in Wisconsin

Chapter 148

148.01 (1) State society. The state medical society of Wisconsin is continued with the general powers of a corporation. It may from time to time adopt, alter and enforce constitution, by-laws and regulations for admission and expulsion of members, election of officers, and management.

(2) A member expelled from a county medical society may appeal to the state society, whose decision shall be final.

(3) (a) The state society, or a county society in manner approved by the state society, shall have the power to establish in the state or in any county or counties therein, a nonprofit plan or plans for the sickness care of indigents and low income groups, and others, through contracts with public officials, and with physicians and others, and by the use of contributions, cooperative funds, and other means, provided only that free choice of physicians within such contracts shall be retained and that responsibility of physicians to patient and all other contract and tort relationships with patient shall remain as though the dealings were direct between physician and patient. Any person covered by or insured under such plan shall be free to choose for sickness care any medical or osteopathic physician, licensed to practice in Wisconsin who has agreed to abide by such plan according to its terms and no such physician or osteopath shall be required to participate exclusively in any such plan.

(b) Such plan shall be exempt from the state insurance laws except those provisions relating to nondiscriminatory rates contained in section 201.53, investments contained in section 201.25 and premium reserves contained in section 201.18 (1).

(c) The society shall file with the commissioner of insurance a written declaration defining the organization and structure of the proposed sickness care plan and its area of operations and shall file any amendments or changes thereto. There shall also be filed with the commissioner specimen copies of all contracts with the insured and with the participating physicians and surgeons and the form of such contracts must be approved by the commissioner.

(d) The provisions of section 148.01 (3) (c) shall not apply to any plan nor to any revisions thereof in existence on the effective date of this paragraph, nor to any contracts for the care of the indigent, nor shall any provision of chapter 148 be construed to apply to any corporation, association or organization not a body corporate under said chapter.

148.02 (1) County societies. The physicians and surgeons, not less than five in number, of the several counties, except those wherein a county medical society exists may meet at such time and place at the county seat as a majority agree upon and organize a county medical society, and when so organized it shall be a body corporate by the name of the medical society of such county, shall have the general powers of a corporation, and may take by purchase or gift and hold real and personal property. County medical societies now existing are continued with the powers and privileges conferred by this chapter.

(2) Physicians and surgeons who, before April 20, 1897, received a diploma from an incorporated medical college or society of any of the United States or territories or of any foreign country, or who shall have received a license from the state board of medical examiners, shall be entitled to meet for organization or become members of the county medical society.

(3) If there be not a sufficient number of physicians and surgeons in any county to form a medical society they may associate with those of adjoining counties, and the physicians and surgeons of not more than fifteen adjoining counties may organize a medical society under this chapter, meeting at such time and place as a majority agree upon.

(4) A county medical society may from time to time adopt, alter and enforce constitution, by-laws and regulations for the admission and expulsion of members, election of officers, and management, not inconsistent with the constitution, by-laws and regulations of the state society.

1841—THE SOCIETY CREATED BY TERRITORIAL LEGISLATURE

The first statutory recognition of the State Medical Society was by act of the Legislative Assembly of the Territory of Wisconsin, in Act 53 of the Territorial Legislature of 1841. The organization of the Society was authorized, with the declaration that ". . . well regulated medical societies have been found to contribute to the advancement and diffusion of true science, and particularly of the healing art. . ."

The organization meeting was set for the second Monday in January, 1842, at Madison, for the purpose of forming ". . . a society under the name and style of the Medical Society of the Territory of Wisconsin. . ." Drs. Bushnell B. Cary, M. C. Darling, Lucius I. Barber, Oliver E. Strong, Edward McSherry, E. W. Wolcott, J. C. Mills, David Walker, Horace White, Jonas P. Russell, David Ward, Jesse S. Hewett, B. O. Miller, and their associates, were authorized by statute to conduct the initial organization of the Society.

Constitution and By-Laws of the State Medical Society of Wisconsin*

CONSTITUTION

ARTICLE I

NAME OF THE ASSOCIATION

The name and title of this organization shall be the State Medical Society of Wisconsin.

ARTICLE II

PURPOSE

The purposes of this Society shall be to federate and bring into one compact organization the entire medical profession of the State of Wisconsin, and to unite with similar societies of other states and territories of the United States to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; and to enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life.

ARTICLE III

COMPONENT SOCIETIES

SECTION 1. Component societies shall consist of those county medical societies which hold charters from this Society.

SEC. 2. The terms, county medical society and component county medical society, shall be deemed to include all county medical societies and academies of medicine now in affiliation with this Society, or which may hereafter be organized and chartered by the House of Delegates of this Society.

ARTICLE IV

COMPOSITION OF THE ASSOCIATION

SECTION 1. This Society shall consist of members who shall be the members of the component county medical societies who have been certified to the headquarters of this Society, and whose dues and assessments for the current year have been received by the secretary.

SEC. 2. Those members who have been elected to honorary membership by the various component county societies may be enrolled as honorary members of this Society upon approval of the Council. These honorary members shall enjoy all the rights of membership, and their dues to the State Society shall be remitted.

SEC. 3. Members in good standing who shall make outright gifts to the Endowment Fund of this Society, in the amount of $1,000 or more, shall have bestowed upon them the gift of life membership in this Society. Such membership shall carry with it all the perquisites of active membership, without the requirement of annual dues, and shall continue in force during the life of the member, providing that the member continues in good standing in his local county medical society.

ARTICLE V

HOUSE OF DELEGATES

The House of Delegates shall be the legislative body of the Society, and shall consist (1) of delegates elected by the component county medical societies, and one delegate representing each Section of the Society organized under the By-Laws and (2) the officers of the Society enumerated in Section 1 of Article IX of this Constitution, and past presidents of the Society shall be ex officio members, but without the right to vote.

ARTICLE VI

COUNCIL

The Council shall be the Board of Trustees of this Society. The Council shall have full authority and power of the House of Delegates, between annual sessions, unless the House of Delegates shall be called into session as provided in the Constitution and By-Laws. It shall consist of the councilors and the immediate past president. The president, the president-elect, the secretary, the treasurer and the speaker of the House of Delegates shall be ex officio members of the Council, but without the right to vote. Nine of its members shall constitute a quorum.

ARTICLE VII

SECTIONS AND DISTRICT SOCIETIES

The House of Delegates may provide for a division of the scientific work of the Society into appropriate sections, and for the organization of such councilor district societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies.

ARTICLE VIII

SESSIONS AND MEETINGS

SECTION 1. The Society shall hold an annual session during which there shall be at least two general meetings, open to all registered members, delegates and guests.

SEC. 2. The place for holding each annual session shall be fixed by the House of Delegates, or, by failure to act, such authority is delegated to the Council. The time for holding each annual session shall be approved by the Council.

SEC. 3. Special meetings of either the Society or the House of Delegates may be called by a two-thirds vote of the Council or upon petition by twenty delegates.

ARTICLE IX

OFFICERS

SECTION 1. The officers of this Society shall be a president, a president-elect, a secretary, a treasurer, councilors from thirteen districts, and a speaker and vice speaker of the House of Delegates.

SEC. 2. The officers, except the councilors, shall be elected annually. The terms of the councilors shall be for three years. There shall be elected one councilor for each of the thirteen districts, except that in any councilor district embracing a membership of 250 or more, there shall be elected one additional councilor for each additional 250 members or major fraction thereof.

As nearly as possible, one third of the members of the Council shall be elected each year. The secretary and the treasurer shall be elected by the Council. All these officers shall serve until their successors are elected and installed.

* As revised by the 1945 House of Delegates.

The president-elect shall automatically succeed the office of president at the conclusion of his one-year term of president-elect.

ARTICLE X

FUNDS AND EXPENSES

SECTION 1. Funds shall be raised by an equal per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates. Funds may also be raised by voluntary contributions, from the Society's publications and in any other manner approved by the House of Delegates. The treasurer and secretary shall submit an annual budget to the Council. All resolutions providing for appropriations shall be referred to the Council and all appropriations approved by the Council shall be included in the annual budget.

SEC. 2. The House of Delegates, by adoption of a by-law, may provide for a special classification of members at per capita reduced dues where such classification may be applied generally throughout the state, and has no special application to individual members or to individual societies.

ARTICLE XI

REFERENDUM

At any general meeting of the Society it may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates. The House of Delegates may, by a vote of its members, submit any question to the membership of the Society for its vote. A majority vote of all the members of the Society shall determine the question.

ARTICLE XII

SEAL

The Society shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

ARTICLE XIII

AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the members of the House present at any annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been published twice during the year in the bulletin or Journal of this Society, or sent officially to each component society at least two months before the meeting at which final action is to be taken.

BY-LAWS

CHAPTER I

MEMBERSHIP

SECTION 1. The name of a physician on the official roster of this Society, after it has been properly reported by the secretary of his county society, shall be *prima facie* evidence of membership and of his right to register at the annual session.

SEC. 2. No person who is under sentence of suspension or expulsion from any component society of this Society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Society.

SEC. 3. Each member in attendance at the annual session shall register, when his right to membership has been verified by reference to the records of this Society. No member shall take part in any of the proceedings of the annual session until he has complied with the provisions of this section of the By-Laws.

CHAPTER II

GENERAL MEETINGS

SECTION 1. The general meetings shall be open to all registered members and guests. At such time as may have been arranged, shall be delivered the annual addresses of the president and of the president-elect.

SEC. 2. No address or paper, except those of the president, the president-elect, and the annual orations, or papers presented by out-of-state speakers especially invited, shall occupy more than twenty minutes in its delivery. No member, except by unanimous consent, shall speak more than once in the discussion of any paper nor longer than five minutes at any one time.

SEC. 3. All papers read before this Society shall be its property. Each paper, when it has been read, shall be deposited with the secretary. Authors of papers read before this Society shall not cause them to be published elsewhere until after they have been published in its Journal or returned by the Editorial Board. Authors who fail to observe this section shall be ineligible to appear on programs of the State Society for a period of five years.

CHAPTER III

HOUSE OF DELEGATES

SECTION 1. The House of Delegates shall meet annually at the time and place of the annual session.

SEC. 2. Each component county society shall be entitled to send each year one delegate or one corresponding alternate to the House of Delegates for each fifty full-paid members or major fraction thereof in this Society provided, however, that each county society shall be entitled to at least one delegate or one corresponding alternate.

For purposes of this section, the number of fully paid members as of a date thirty days in advance of the first session of the House of Delegates at the annual meeting shall determine the number of delegates to which a county medical society may be entitled.

The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society at least thirty days before the annual session. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

SEC. 3. One-fourth of the members of the House of Delegates registered shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Society.

SEC. 4. From among members of the House of Delegates the speaker of the House of Delegates, for the purpose of expediting proceedings, shall appoint Reference Committees to which reports and resolutions shall be referred as follows:

a. On Credentials.
b. On Resolutions.
c. On Reports of Officers.
d. On Reports of Standing Committees.

He shall also appoint such other committees as may be considered by him to be necessary.

SEC. 5. The House of Delegates shall elect delegates to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body.

SEC. 6. The House of Delegates shall divide the state into councilor districts, specifying what counties each district shall include, and, when the best interest of the Society and the profession will be promoted thereby, organize in each a district med-

ical society, of which all members of the component county societies shall be members.

SEC. 7. The House of Delegates shall have authority to appoint committees for special purposes from among members of the Society who are not members of the House of Delegates. Such committees shall report to the House of Delegates, and may be present and participate in the debate on their reports.

SEC. 8. It shall approve all memorials and resolutions issued in the name of the Society before they shall become effective.

SEC. 9. Unanimous consent of the House of Delegates shall be required for the introduction of any new resolution or business not filed in proper form with the secretary's office of the Society twenty days before the first session of the House of Delegates. This section shall not apply to new business or resolutions presented by the Council, the constitutional officers, committees of the Society or of the House of Delegates, or officers of the House of Delegates.

CHAPTER IV

ELECTION OF OFFICERS

SECTION 1. The House of Delegates at its first meeting at the annual session shall elect a Committee on Nominations consisting of one delegate from each councilor district. The Committee on Nominations shall report the result of its deliberations to the House of Delegates in the form of a ticket containing the names of one or more members for each of the offices to be filled at that annual session. No two candidates for president-elect shall be from the same district. Each candidate for councilor must be a resident of the district for which he is nominated. Nominations for councilor shall be made from the floor and not from the Committee on Nominations.

SEC. 2. The report of the nominating committee and the election of officers shall be the first order of business of the House of Delegates at the third meeting of the House.

SEC. 3. All elections of officers, where more than one nomination is received, shall be by ballot and a majority of the votes cast shall be necessary to elect except for delegates and alternates to the American Medical Association. In case no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of all the votes cast, when he shall be declared elected. In case no delegates or alternates for the American Medical Association receive on the first ballot a majority of the vote, the nominees shall be declared elected in the order of the highest number of votes received, until the allotted number shall have been chosen. In case of a tie vote for delegate or alternate, the tie shall be determined by lot.

SEC. 4. Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

SEC. 5. No person known to have solicited votes for or sought any office within the gift of this Society shall be eligible for any office for two years.

CHAPTER V

DUTIES OF OFFICERS

SECTION 1. The president shall preside at all meetings of the Society; he shall appoint a Committee on Arrangements for the annual session and all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and, as far as practicable, shall visit, by appointment, the various sections of the state and assist the councilors in building up the county societies, and in making their work more practical and useful.

SEC. 2. The president-elect shall act for the president in his absence or disability. If the office of president should become vacant the president-elect shall succeed to the presidency. In case of vacancy in the office of both president and president-elect the Council shall appoint one of its members as acting president until the next meeting of the House of Delegates.

SEC. 3. The treasurer shall give bond in such amount as the Council may provide. He shall demand and receive all funds due the Society, together with bequests and donations. He shall pay money out of the treasury only on a written order of the secretary; he shall subject his accounts to such examination as the House of Delegates may order, and he shall annually render an account of his doings and of the state of the funds in his hands.

SEC. 4. The secretary shall attend the general meetings of the Society and the meetings of the House of Delegates, and shall keep minutes of their respective proceedings. He shall be secretary of the Council. He shall be custodian of all record books and papers belonging to the Society, except such as properly belong to the treasurer, and shall keep account of and promptly turn over to the treasurer all funds of the Society which come into his hands. He shall provide for the registration of the members and delegates at the annual session. He shall, with the cooperation of the secretaries of the component societies, keep a card index register of all the legal practitioners of the state by counties, noting on each his status in relation to his county society, and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council and shall make an annual report to the House of Delegates. He shall supply all component societies with the necessary blanks for making their annual reports, and shall collect from them the regular per capita assessments and turn the same over to the treasurer. The amount of his salary shall be fixed by the Council.

SEC. 5. The speaker shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

SEC. 6. The vice-speaker shall officiate for the speaker in the latter's absence or at his request. In case of death, resignation, or removal of the speaker, the vice-speaker shall officiate during the unexpired term.

CHAPTER VI

COUNCIL

SECTION 1. The Council shall meet on the day preceding the annual session, and daily *if necessary* during the session and at such other times as necessity *may* require, subject to the call of the chairman or on petition of three councilors. It shall hold an annual meeting during January for purposes of or-

ganization and other business. Its chairman shall make an annual report to the House of Delegates.

SEC. 2. Each councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep in touch with the activities of and to aid in the betterment of the component societies of his district. He shall make an annual report of his work, and of the condition of the profession of each county in his district at the annual session of the Council. The necessary traveling expenses incurred by each councilor in the line of duties herein imposed may be allowed on a proper itemized statement, but this shall not be construed to include his expense in attending the annual session of the Society.

SEC. 3. The Council shall be the executive body of the House of Delegates and between sessions shall exercise the power conferred on the House of Delegates by the Constitution and By-Laws.

The Council shall be the Board of Censors of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Society. All questions of an ethical nature brought before the House of Delegates or the general meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or component societies, on which an appeal is taken. Its decision in all cases, including questions regarding membership in this Society, shall be final.

SEC. 4. Charters shall be issued to county societies only on approval of the Council, and shall be signed by the president and secretary of this Society. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and By-Laws.

SEC. 5. In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designed so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

SEC. 6. The Council shall provide for and superintend the issuance of all publications of the Society including proceedings, transactions and memoirs, and shall have authority to appoint an editor of the Journal and such assistants as it deems necessary. It shall prescribe the methods of accounting and through a committee of three of its members to be known as a Committee on Auditing and Finance, shall audit all accounts of this Society, and with the treasurer, supervise the investment of funds. The Council shall adopt an annual budget providing for the necessary expenses of the Society, which shall be prepared and presented for its consideration by the treasurer and secretary at the first meeting of the Council in January of each year. Its chairman shall submit an annual report to the House of Delegates, which shall specify the character and cost of the publications of the Society, the amount and character of all of its property, and shall provide full information concerning the management of all affairs of the Society which the Council is charged to administer.

SEC. 7. The Council shall, by appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between annual meetings of the House of Delegates; the appointee shall serve until his successor has been elected and has qualified.

SEC. 8. The Council may elect as secretary one who need not be a physician nor a member of the Society.

SEC. 9. The salaries of all employees of the Society shall be fixed by the Council.

SEC. 10. The Council shall provide such headquarters for the Society as may be required to conduct its business properly.

CHAPTER VII

COMMITTEES

SECTION 1. The standing committees of this Society shall be as follows:

A Council on Scientific Work.
A Council on Medical Service and Public Relations.
A Committee on Public Policy.
A Committee on Grievances.
A Committee on Medical Education and Hospitals.
A Committee on Medical Economics and Voluntary Sickness Insurance.
A Committee on Maternal and Child Welfare.
A Committee on Health and Public Instruction.
A Committee on Coordination of Medical Services.
A Committee on Care of Crippled Children.
A Committee on Goiter.
A Committee on Mental Hygiene and Institutional Care.
A Committee Advisory to the Woman's Auxiliary.
A Committee on Tuberculosis and Chest Diseases.
A Committee on Industrial Health.
A Committee on Hospital Relations.
A Committee on Cancer.
A Committee on Visual Defects.
A Committee on Hearing Defects.
A Committee on Rural Health and Accident Prevention.

Unless otherwise provided in these By-Laws, each of these committees shall consist of three members, each of whom shall serve for a term of three years. One member of each of these committees shall be appointed annually by the incoming president, by and with the consent of the House of Delegates, provided that where the House creates a new standing committee the original appointments shall be for terms of one, two, and three years, and thereafter for terms of three years each.

SEC. 2. The Council on Scientific Work shall consist of five members, and each member shall serve for a period of five years. The Council on Scientific Work shall study the character and scope of the scientific proceedings of the Society and shall prepare the scientific program for the annual meeting. It shall likewise study the field of postgraduate education, making available, so far as lies within its power, program material for such postgraduate education both through programs of component societies and in such other ways as it may find feasible. It shall also be in charge of the affairs of the Journal. Important questions of editorial policy shall be submitted to the Council of the Society and an annual report shall be made to the House of Delegates.

SEC. 3. The Council on Medical Service and Public Relations shall consist of the chairman of the Council, the president, the past president, the speaker of the House of Delegates, and five members appointed annually by the president of the Society. The Council on Medical Service and Public Relations shall act to correlate activities of the Society in medical economic fields, and to inform the profession and the public of proposed changes affecting medical care in the state and the nation. It shall likewise study and suggest means for the improvement of the distribution of medical service to the

public, and shall periodically inform county medical societies regarding its activities.

SEC. 4. The Committee on Public Policy shall consist of three members, and the president, the president-elect and secretary. The committee shall present to those public officers charged with the duty of enacting or enforcing measures in the interest of public health, all available information that may in any way assist such officers honorably to discharge their responsibilities.

SEC. 5. The Committee on Grievances shall investigate all reported claims against members for compensation for injuries said to have resulted from malpractice. It shall determine as nearly as may be practicable the circumstances leading up to the making of the claim itself and the grounds on which the claim is based. The committee shall recommend to the Society from time to time such measures as it deems practicable for the limitation or removal of the causes of such claims. It may, at the request of any member against whom a claim has been made, place at his disposal such evidence as becomes available to the committee. If the committee believes a claim unjust, it shall, at the request of the member against whom the claim has been made, cooperate, so far as it can lawfully do so, with him and his counsel in defense against it. If the committee believes that the claim that it has investigated is a just claim, the committee may, at the request of the member against whom the claim was made, cooperate with him and his counsel, so far as it lawfully can do so, in effecting an equitable settlement. The committee shall submit a report of its proceedings at each annual meeting of the Society, covering the preceding year, in which report shall be included all recommendations made by the committee during the year looking toward the removal of the causes of claims based on alleged malpractice.

SEC. 6. The Committee on Medical Education and Hospitals shall serve in this state for the Council on Medical Education and Hospitals of the American Medical Association, and shall have referred to it all questions pertaining to hospitals and medical education.

SEC. 7. The Committee on Medical Economics and Voluntary Sickness Insurance shall be charged with the responsibility of reporting annually to the House of Delegates such recommendations as may, in its judgment, seem proper with reference to the subject of medical economics and voluntary sickness insurance. The committee shall consist of six members, and each member shall serve for a period of three years. Of the original appointments, two members shall be appointed for a term of one year, two members for a term of two years, and two members for a term of three years each.

SEC. 8. The Committee on Maternal and Child Welfare shall consist of six members and its principal duties shall be to advise cooperating agencies in the effort to reduce maternal mortality and to preserve child health.

SEC. 9. The Committee on Health and Public Instruction shall consist of three members. It shall carry on such activities in the field of health and the dissemination of information in relation thereto as the House of Delegates and Council may direct.

SEC. 10. The Committee on Care of Crippled Children shall consist of six members, and its principal duty shall be to act in an advisory capacity to state departments concerned with the subject matter.

SEC. 11. The Committee on Goiter shall consist of three members, and its principal duty shall be to forward those measures looking toward the prevention of goiter, and where existent, its early diagnosis and treatment.

SEC. 12. The Committee on Mental Hygiene and Institutional Care shall consist of three members, and its principal duties shall be advisory to both the Society and cooperating agencies as to those means best designed to protect mental health and to alleviate mental illnesses.

SEC. 13. The Committee Advisory to the Woman's Auxiliary shall consist of the chairman of the Council, the immediate past president, the president, the president-elect, and the secretary. Its principal duties shall be to advise state officers of the Auxiliary, particularly in the field of approval of new projects.

SEC. 14. The Committee on Tuberculosis and Chest Diseases shall consist of three members, and its principal duties shall be advisory to the Society and cooperating agencies as to those means best designed to aid in the prevention and alleviation of tuberculosis and diseases of the chest.

SEC. 15. The Committee on Industrial Health shall consist of three members, and its principal duties shall be to cooperate with the Council on Industrial Health of the American Medical Association, and to seek to further the health of those employed in industry in Wisconsin.

SEC. 16. The Committee on Hospital Relations shall consist of six members, and each member shall serve for a period of three years. Of the original appointments, two members shall be appointed for a term of one year, two members for a term of two years, and two members for a term of three years, and thereafter for terms of three years each. The principal duty of this committee shall be to consider, investigate and study the interrelationship of the medical profession to the hospital institutions, and to act in an advisory capacity to the Society.

SEC. 17. The Committee on Cancer shall consist of a member appointed from each of the councilor districts of the State Society, and its principal duties shall be advisory to the Society and cooperating agencies as to those means best designed to aid in the prevention and alleviation of cancer. As nearly as possible, the terms of one-third of the members of the committee shall expire each year, with each committee member being appointed for a term of three years.

SEC. 18. The Committee on Visual Defects shall consist of three members, and its principal duties shall lie in the field of prevention, and where existent, early discovery and treatment. It shall act in an advisory capacity to state departments concerned with these problems.

SEC. 19. The Committee on Hearing Defects shall consist of three members, and its principal duties shall lie in the field of prevention, and where existent, early discovery and treatment. It shall act in an advisory capacity to state departments concerned with these problems.

SEC. 20. The Committee on Rural Health and Accident Prevention shall consist of three members and shall engage in activities in promoting health and safety in rural Wisconsin.

SEC. 21. Reports of the standing and special committees shall be published in the official Journal preceding the date of the annual session of this Society, and these reports must be in the hands of the secretary sixty days in advance of the annual session.

CHAPTER VIII

DUES AND ASSESSMENTS

SECTION 1. The annual dues and assessments shall be determined by the House of Delegates, and shall be levied per capita on the members of the Society. They shall be payable on or before January 1 of the year for which they are levied.

The secretary of each component society shall cause to be collected and shall forward to the offices of the Society the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the secretary of this Society on or before March 31 shall stand suspended until his name is properly reported and his dues for the current year properly remitted.

An active member who shall have attained his eightieth year and shall have been a member of his county medical society in Wisconsin or elsewhere in the United States continuously since beginning the practice of medicine, or who for fifty years shall have been continuously a member of his county medical society in Wisconsin or elsewhere in the United States, shall, upon establishing the above facts to the satisfaction of his county society, and upon the recommendation of such society, be granted the status of a life member. Such member shall enjoy full membership privileges, and shall be exempt from the payment of further dues or assessments, and a certificate of special membership shall be issued to him annually.

An active member in good standing in his county society may, upon the recommendation of such society, be granted affiliate membership with full voting and other privileges where one or more of the following conditions exists: retirement from practice; physical or other disability of a character preventing the practice of medicine; a serious and prolonged illness; or financial reverses. Affiliate membership shall be on an annual basis only, and a member must be recommended each year for such special status by the secretary and president of his county medical society following a review and reassessment of his particular situation. An affiliate member shall enjoy full membership privileges and shall be exempt from the payment of dues and assessments during the year in which he is granted such status, and a certificate of membership shall be issued to him for such year.

An active member in good standing in his county society who has for thirty-five continuous years been a member of this State Society shall receive a special certificate and plaque indicating the completion of such period of membership.

SEC. 2. The record of payment of dues and assessments on file in the offices of the Society shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Society and of the House of Delegates.

SEC. 3. Any county society which fails to make the reports required, at least thirty days before the annual session of the State Society, shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Society or of the House of Delegates.

CHAPTER IX

The ethical principles governing the members of the American Medical Association shall govern members of this Society. No member shall profess adherence or give support to any exclusive dogma, sect or school.

CHAPTER X

The deliberations of this Society, except as may be provided otherwise in the Constitution and By-Laws, shall be conducted in accordance with parliamentary usage as defined in Roberts' Rules of Order.

CHAPTER XI

SECTION 1. All county societies now in affiliation with the State Society or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and By-Laws shall, upon application to the Council, receive charters from this Society, provided that their constitutions and by-laws shall have been submitted to the Council and received its approval.

SEC. 2. Only one component medical society shall be chartered in each county.

SEC. 3. Each county society shall judge of the qualifications of its members, subject to review and final decision by the Council of the State Society. Every reputable and legally qualified physician who is a citizen of the United States and who is a bona fide resident of the same county shall be eligible to apply for membership so long as he does not practice nor profess to practice sectarian medicine, or engage in practice in a manner in conflict with the Principles of Ethics of the American Medical Association, or so conduct himself as to defeat the purposes for which the Society is organized and is operating. By proper provision of constitution and by-laws, either or both as may be necessary, the county society may require of an applicant for membership that he shall have resided within the jurisdiction of the society to which he is applying, for a period of one year as a condition precedent to election to membership; or the county society may provide that an applicant for membership first may be elected to membership for a term of only one year, with the provision that such membership shall then terminate, and the member resubmit to election, without limitation as to term, by vote of the society.

A member of a component society whose license has been revoked shall be dropped from membership automatically as of the date of revocation. The Council of the State Society shall have final authority to expel a member should a component county society fail to do so after being so requested by the Council.

A physician living near a county line may hold his membership in that county most convenient for him to attend, on permission of the component society in whose jurisdiction he resides.

A member who removes his principal practice from within the territorial limits of a county medical society in which he shall hold membership, shall not be eligible to continue his membership in such society after the expiration of the calendar year in which such removal shall have occurred. Such member shall, however, be eligible to apply for membership anew or by transfer to the society in whose jurisdiction his principal practice shall have been removed.

By proper provision of Constitution and By-Laws, either or both as may be necessary, a county society may admit to membership those in training as hospital residents or as research fellows who are licensed to practice medicine and surgery in the state of Wisconsin, upon the payment of dues not to exceed $5 annually, of which at least $3 shall be remitted to the State Society, provided that any applicant so elected shall not be permitted such membership beyond a period of three years from the date of such election, and shall not be included as a "fully paid" member as that term is used in Section 2 of Chapter III.

SEC. 4. Any physician who may feel aggrieved by the action of the society of his county in suspending or expelling him shall have the right to appeal

to the Council, whose decision shall be final. A county society shall at all times be permitted to appeal or refer questions involving membership to the Council of the State Society for final determination. The period of time within which appeal to the Council may be taken shall be limited to six months following the date of decision by the constituted authority of a component county medical society.

SEC. 5. In hearing appeals the Council may admit oral or written evidence as in its judgment will most fairly present the facts, but in the case of every appeal both as a board and as individuals, the councilors shall, preceding all such hearings, make efforts at conciliation and compromise.

SEC. 6. When a member in good standing in a component county society moves to another county in this state, he shall be given a written certificate of these facts by the secretary of his society, without cost, for transmission to the secretary of the society in the county to which he moves. Pending his acceptance or rejection by the society in the county to which he removes, such member shall be considered to be in good standing in the county society from which he was certified and in the State Society to the end of the period (respectively) for which his dues have been paid.

SEC. 7. Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician in the county.

SEC. 8. At some meeting in advance of the annual session of this Society, each component county society shall elect one or more delegates and an equal number of individual alternates therefor to represent it in the House of Delegates of this Society, in accordance with Chapter III, Section 2, of these By-Laws. The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society at least thirty days before the annual session. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

SEC. 9. The secretary of each county society shall keep a roster of its members, and, if practicable, a list of nonaffiliated physicians, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary by Council. He shall send a copy of the program of each county meeting to his district councilor and to the secretary.

SEC. 10. Each county society shall appoint or elect one or more of its members as a member of an auxiliary Committee on Public Policy, and the county society secretary shall send his name and address at once to the secretary of this Society. The Committee on Public Policy of this Society shall formulate the duties of this auxiliary committee and supply each member with a copy. The auxiliary committeemen shall be accountable to their county societies and to the Council for prompt response to and continued cooperation with the Committee on Public Policy of this Society.

SEC. 11. This Society shall recognize as a special service member any physician who is in the armed forces of the United States, who has been licensed to practice medicine and surgery in Wisconsin, and who has not previously been a member of any county medical society. Such physician shall first have been accepted as a special service member by a component county society in accordance with the provisions of its Constitution and By-Laws, and the fact of such membership certified to this Society. Application for such special service membership shall not be dependent upon the place of previous residence or the place or period of previous practice, and such membership shall include all the rights and privileges of active membership excepting those of voting and holding office.

No dues shall be assessed against such member until the month following his discharge from the armed forces of the United States, at which time he shall pay prorated dues for the balance of the calendar year of his discharge from service. Special service membership shall lapse at the close of the calendar year of the discharge of each such member from service.

CHAPTER XII

SCIENTIFIC SECTIONS

SECTION 1. The House of Delegates shall, from time to time, establish such scientific sections within the Society as it may determine and shall have the power to combine, enlarge, or discontinue any or all of such sections so established.

SEC. 2. Such sections so established shall be based upon those divisions of medicine in which the various members possess a special interest, but qualifications for membership in any section may be prescribed by the members of such section, subject only to approval of the Council, except that scientific meetings of the section shall be open to all members in good standing of the State Medical Society.

SEC. 3. The officers of any such section shall be those prescribed by the members thereof. The terms of such officers shall be for the term of one year, but any officer may be reelected.

SEC. 4. The officers of any such section shall constitute the executive committee thereof, and a majority of the executive committee must vote with the majority of the members in order for any action of the section to be effective. The executive committee shall have the power to appoint such committees within a section as it deems necessary from time to time.

SEC. 5. No section shall have the power to bind the Society by any resolution or other action, or to publicize the same, unless the same shall first be approved by the House of Delegates, or by a majority of the members of the Council when the House of Delegates is not in session. No resolution adopted by any section shall be effective until likewise so approved.

SEC. 6. Each section so established shall have the privilege of electing a delegate and alternate to the House of Delegates.

CHAPTER XIII

SECTION 1. These By-Laws may be amended at any annual session by a majority vote of the delegates present at that session, if the proposed amendment has been properly submitted to the House of Delegates and has laid on the table for one day.

SEC. 2. Upon the adoption of this Constitution and these By-Laws, all previous Constitutions and By-Laws are thereby repealed.

Members, State Medical Society of Wisconsin*

Abbotsford:
Shields, G. G.

Abrams:
Faulds, R. C.

Adams:
Harris, A. J.
Ingersoll, B. P.
Shapiro, Harry

Adell:
Bemis, I. M.
Naylen, F. J.
Schilling, R. F.

Albany:
Bongiorno, F. J.
Weismiller, L. L.

Algoma:
Bertram, B. J.
Witcpalek, W. W.

Allenton:
Fisher, R. S.

Alma:
Bachhuber, M. O.

Almena:
Arneson, Thomas

Amery:
Cornwall, W. B.
Ford, K. K.
Kremser, V. C.
Rechlitz, E. T.
Waterman, I. L.

Amherst:
Dorsch, J. F.

Antigo:
Bloor, E. G.
Curran, W. P.
Donohue, M. J.
Dorzeski, E. F.
Flatley, M. A.
Lambert, J. W.
McKenna, E. A.
Moore, G. E.
Zellmer, C. E.

Appleton:
Archer, W. E.
Benton, J. L.
Bolton, E. L.
Brooks, E. H.
Carlson, G. W.
Cherkasky, Simon
Dehne, W. O.
Frawley, W. J.
Gallaher, D. M.
Giffin, W. S.
Gloss, A. J.
Harrington, Wm. J.
Hegner, G. T.
Huberty, F. J.
Konz, S. A.
Krueger, E. N.
Laird, J. W.
Landis, R. V.
MacLaren, J. B.
Marshall, V. F.
McBain, L. B.
McCarty, R. T.
McGrath, E. F.
Mielke, E. F.
Neldhold, C. D.
Pansch, F. N.
Pardee, C. A.
Rankin, F. J.
Rector, A. E.
Reeve, J. S.
Swanton, M. E.
Taylor, A. C.
Vande Loo, F. B.
Young, J. J.
Zeiss, E. J.

Arcadia:
Comstock, Elizabeth
Dockendorff, B. C.
Haines, B. J.
Weber, F. T.

Ashland:
Andrus, A. D.
Bargholtz, W. E.
Butler, Albert
Dodd, J. M., Sr.
Grand, C. A.
Grigsby, R. O.
Harrison, G. W.
Kamm, A. X.
Lamal, A. H.
Prentice, J. W.
Smiles, C. J.
Tucker, W. J.
Weeks, F. D.

Athens:
Bachhuber, G. J.
Bachhuber, H. M.
Frick, Lewis

Augusta:
Moland, O. G.
Thieda, E. S.

Baldwin:
Kunny, B.
Sargeant, G. M.
Swenson, G. B.

Bangor:
Ruppenthal, K. P.
Ward, M. W.

Baraboo:
Braun, R. F.
Cahoon, Roger
Edwards, A. C.
Huth, M. F.
Irwin, H. J.
Moon, J. F.
Pearson, C. R.
Pope, C. B.
Tryon, F. E.
Vander Kamp, H.
Winslow, F. R.

Barron:
Coleman, H. M.
Post, C. C.
Ruethin, K. A.
Schlomovitz, H. H.
Smith, R. C.

Bayfield:
Moody, L. W.

Bear Creek:
Morneau, L. F.

Beaver Dam:
Clarke, T. C.
Corso, Xavier
Costello, W. H.
Hammond, A. W.
Hoyer, A. A.
Hoyer, E. C.
Hoyer, G. H.
Kores, A. B.
Roberts, Rob Roy
Rosenhelmer, A. M.
Schoen, R. F.
Temkin, M. M.
Webb, E. P.
Welsch, J. M.

Belleville:
Donlin, W. F.

Beloit:
Allen, J. P.
Allen, W. J.
Brinckerhoff, F. E.
Brown, E. B.
Burger, H. E.
Carney, C. M.
Cochrane, W. L.
Crockett, W. W.
Crone, V. D.
Flarity, T. H.
Fosse, B.
Friend, L. J.
Friske, O. W.
Gunderson, R. H.
Helm, H. M.
John, G. W.
Kasten, H. E.
Keithley, J. W.
Kishpaugh, H. W.
Mauermann, W. J.
Ottow, A. F.
Raube, H. A.
Ross, M. E.
Shearer, H. A.
Smith, C. E.
Springberg, J. C.
Sweeney, T. C.
Thayer, R. A.
Vivian, R. S.

Berlin:
Koch, H. C.
Seward, L. J.
Stone, G. C.
Stone, Mildred M.
Wiesender, A. J.

Big Bend:
Boldt, R. E.

Birnamwood:
Damp, O. E.
McCandless, E. E.

Black River Falls:
Krohn, Irwin
Krohn, Robert
Manz, K. F.

Bloomer:
Clauson, C. T.
Hudek, D. F.

Bloomington:
Edwards, P. K.

Blue Mounds:
Bancroft, H. V.

Blue River:
Randall, M. W.

Bonduel:
Klopf, H. M.
Terlinden, J. H.

Boscobel:
Freymiller, E. F.
Hayman, C. S.
Pippin, L. M.
Spiegelberg, E. H.

Brandon:
Hull, H. H.
Lautenbach, E. T.

Brillion:
Goelz, J. R.
Wagner, A. J.

Brodhead:
Mitchell, E. J.
Stuessy, M. W.

Brownsville:
Raymond, R. G.
Ries, M. F.

Bruce:
Whalen, M. L.

Burlington:
Alcorn, M. W.
Bennett, J. F.
Carroll, J. H.
Granzeau, H. W.
Mastallr, L. O.
Moran, C. J.
Mullen, R. A.
Murawsky, W. J.
Newell, F. F.
Reinardy, A. L.

Cadott:
Zenner, C. E.

Cambria:
Ronneburger, E. O.

Cambridge:
Amundson, K. K.
Bilstad, G. E.

Cameron:
Cronk, C. F.

Campbellsport:
Guenther, O. F.
Hoffmann, L. A.

Casco:
Kerscher, E. J.

Cashton:
Cremer, C. H.
Mauel, N. M.

Cato:
Kelley, J. M.

Cedarburg:
Blanchard, P. B.
Hurth, O. J.
Hurth, O. W.

Cedar Grove:
Van Altena, L. A.
Voskull, A.

Centuria:
Noyes, G. B.

Chaseburg:
Richter, J. R.

Chetek:
Adams, R. W.

Chilton:
Goggins, J. W.
Hardin, C. A.
Knauf, N. J.
Minahan, J. J.
Rathert, E. T.

Chippewa Falls:
Field, Merton
Hatleberg, C. B.
Henske, W. C.
Hunter, H. R.
Kelly, J. A.
McCarty, E. O.
McHugh, F. T.
Picotte, L. W.
Sazama, F. B.
Sazama, J. J.
Somers, A. J.
Williams, S. E.

Clayton:
Campbell, L. A., Jr.

Clear Lake:
Campbell, L. A.
Nelson, A. N.

Clinton:
Thomas, W. O.

Clintonville:
Auld, Irving
Miller, E. A.
Topp, C. A.

Cochrane:
Melli, E. A.

Colby:
Christofferson, H. H.
Schemmer, A. L.

Coleman:
Graner, L. H.

Colfax:
Cooper, C. A.
Felland, O. M.

Columbus:
Caldwell, H. M.
Chell, C. F.
Frederick, A. J.
Mudroch, J. A.
Poser, E. M.
Poser, J. F.

Coon Valley:
Solberg, A. A.

Crandon:
Ison, G. W.

* As of December 27, 1945.

Cross Plains:
Froggatt, W. E. L.
Lappley, W. F.

Cuba City:
Balr, F. M.
Terry, R. E.

Cudahy:
Ackerman, E. J.
Fine, J. M.
Kash, S. H.
Kierzkowskl, C. V.
Krueger, B.
Landsberg, M.
Partrldge, C. D.

Cumberland:
Lund, S. O.
Thompson, R. C.

Darlen:
Levln, H. M.

Darlington:
McConnell, E. D.
McGreane, N. A.
Quinn, R. B.

Deerfield:
Ingwell, C. L.

Deer Park:
Dasler, T. W.

De Forest:
Carlton, E. P.
Grinde, J. M.
Knudtson, K. P.
Tweetem, J. K.

Delafield:
Barnes, H. T.
Olsen, L. C. J.

Delavan:
Crowe, N. F.
Jacobson, T. L.
Kenney, H. J.
O'Kecfe, F. L.
Wright, C. A.

Denmark:
Hager, F. J.
Michna, C. T.
Schlilling, H. J.
Schoenenberger, A. P.
Vosburgh, W. H.

De Pere:
Kersten, N. M.
Lenfestey, J. P.
Waldkirch, R. M.

De Soto:
Bolstad, H. A.
Gorenstein, L. M.

Dodgeville:
Buckner, H. M.
Hagerup, T. A.
Hamllton, W. P.
Morton, H. H.
Reese, William
Walker, H. M.

Dorchester:
Foley, F. P.

Dousman:
Armstrong, C. A.
Notbohm, W. R.

Durand:
Bryant, R. J.

Eagle:
Fltzgerald, J. J.
Schmidt, F. M.

Eagle River:
Llndstrom, C. O.
Oldfield, R. A. A.

East Troy:
Meany, S. G.
O'Leary, T. J.

Eau Claire:
Anderson, F. G.
Beebe, G. W.
Blom, Jullus
Buckley, R. A.
Culver, L. G.
Derge, H. F.
Falstad, C. H.
Fuson, H. S.
Haag, A. F.
Hatleberg, E. J.
Hayes, E. P.
Henke, S. L.
Hoyme, G.
Huston, H. C.
Ihle, C. M.
Johnson, Fred
Klncaid, C. K.
Klnsman, F. C.
LaBreck, F. A.
Lowe, J. W.
Manz, W. R.
Mason, E. L.
Mautz, W. T.
Meyn, A. W.
Mldelfart, Peter
Mitchell, Mancel
Niver, E. O.
Paulson, W. O
Richards, R. R.
Rosen, T. S.
Russell, S. B.
Spelbring, P. G.
Stang, H. M.
Strand, R. C.
Tanner, J. W.
Werner, R. F.
Willison, D. M.
Wlshart, J. H.
Zlegler, J. E. B.

Eden:
Hardgrove, J. H.

Edgar:
Schulz, H. A.

Edgerton:
Burpee, G. F.
Shearer, A. T.
Shearer, F. E.
Sumner, W. C.

Elcho:
Dailey, P. J.

Elkhart Lake:
Martlneau, J. E.

Elkhorn:
Helmbrecht, M. G.
Rawlins, J. A.
Ridgway, E. T.
Sorenson, E. D.
Young, J. H.

Ellsworth:
Aanes, A. R.
Cannon, C. R.
Nordholm, V. W.
Svec, F. A.

Elm Grove:
Kriz, G. A.
Wheelihan, R. Y.

Elmwood:
Breed, A. L.

Elroy:
Vogel, C. A.

Ettrick:
Rogne, C. O.

Evansville:
Gray, R. J.
Sorkin, S. S.

Fall Creek:
Zboralske, F. F.

Fennimore:
Balley, M. A.
Howell, E. C.
Marsden, T. H.
Schuler, W. H.

Fond du Lac:
Becker, N. O.
Borsack, K. K.
Calvy, D. W.
Connell, John W.
Dalrymple, R. R.
Dana, R. L.
Devine, H. A.
Devine, J. C.
Finn, W. C.
Florin, A. C.
Folsom, W. H.
Gardner, L. C.
Gavln, S. E.
Glienke, C. F.
Huebner, J. S.
Hutter, A. M.
Keenan, L. J.
Leonard, C. W.
McCabe, P. G.
Meiklejohn, D. V.
Pawsat, E. H.
Randall, E. M.
Rehorst, J. J.
Sharpe, H. R.
Sharpe, H. R., Jr.
Sharpe, J. J.
Slmon, L. J.
Smlth, E. V.
Smlth, E. V., Jr.
Temple, J. W.
Theisen, S. A.
Trler, P. J.
Twohlg, D. J.
Twohig, D. J., Jr.
Twohlg, H. E.
Twohig, J. E.
Waffle, R. F.
Waldschmldt, W. J.
Walters, D. N.
Wier, J. S.
Wiley, F. S.
Wojta, W. C.
Yockey, J. C.

Footvlle:
Harvey, J. R.

Forestvlle:
Hlrschboeck, J. G.

Ft. Atklnson:
Caswell, H. O.
Gruesen, F. A.
Gueldner, L. H.
Hanson, O. H.
Harrls, J. J.
Morris, R. C.
Notbohm, D. R.
Venning, J. R.
Young, Will

Fountain City:
Skemp, F. C.

Fox Lake:
Elllott, E. S.

Frederic:
Andrews, W. C.
Arveson, R. G.

Fremont:
Arnoldussen, C. P.

Friendship:
Treadwell, G. F.

Galesvlle:
Alvarez, R. L.
Jegl, H. A.

Gays Mills:
Boyce, S. R.

Genesee Depot:
Jones, G. S.

Gillett:
Baldwln, L. H.
Berg, W. R.

Gilman:
Cramp, A. L.

Glenbeulah:
Hansen, John

Glenwood City:
Love, R. C.
McCusker, C. F.

Glidden:
Ansfield, F. J.

Goodman:
Kingsbury, C. H.
Steinke, C. G.

Grafton:
Balkwill, C. A.
Kalb, C. H.

Green Bay:
Atklnson, H. S.
Bartran, W. H.
Bolles, C. S.
Brusky, A. H.
Buchanan, R. C.
Burdon, T. S.
Burns, Robert W.
Charboneau, A. A.
Clifford, P. M.
Collgnon, J. C.
Cowles, R. L.
Crlkelalr, F. L.
Denys, G. F.
Denys, K. J.
Dockry, P. F.
Dupont, A. J.
Ellingson, O. A.
Ford, J. L.
Ford, W. W.
Freedman, A. L.
Fuller, M. H.
Gosin, D. F.
Gosln, F. J.
Grossman, M. A.
Hagerty, W. T.
Halloin, J. E.
Heitzman, H. H.
Hendrlckson, H.
Icks, K. R.
Jordan, E. M.
Kelly, W. W.
Killeen, E. D.
Klllins, W. A.
Klspert, R. W.
Kuhl, F. O.
Leaper, W. E.
Levltas, I. E.
McCarey, A. J.
McNevins, E. S.
Merline, G. B.
Meyer, M. W.
Milson, Louis
Minahan, P. R.
Mokrohajsky, S. M.
Nadeau, E. G.
Olmsted, A. O.
Qulgley, L. D.
Robb, J. J.
Saunders, O. W.
Schmidt, E. S.
Senn, George
Shinners, G. M.
Stauff, G. R.
Stiennon, O. A.
Tlppet, W. P.
Troup, R. L.
Troup, W. J.
Weaver, D. F.
Willlamson, C. S.

Greendale:
McMurry, O. R.

Greenwood:
Olson, W. A.

Gresham:
Litzen, F. L.
Schmidt, R. F.

Hales Corners:
Heil, J. V.
Pierce, D. F.
Wolf, R. C.

Hammond:
Olson, C. A.

Hartford:
Hoffmann, J. G.
Lehmann, F. W.
Monroe, M. E.
Quackenbush, E. C.
Sachse, F. W.

Hartland:
Brewer, G. W.
Grover, F. L.

Hawthorne:
Nezworski, L. G.

Hayward:
Callaghan, D. H.
Dufour, E. H.
Krueger, E. R.
Wesche, G. E.

Hazel Green:
Strauch, C. B.

Highland:
Erlckson, M. T.

Hilbert:
Winkler, R. J.

Hillsboro:
Hansberry, P. H.
MacKechnie, R. S.

Hixton:
Petzke, E. A.

Hollandale:
Marshall, S. B.

Holmen:
Hanson, L. E.

Horicon:
Bloom, C. S.
Drescher, G. G.
Federman, E. H.
Karsten, J. H.

Hortonville:
Adrians, W. A.
Towne, W. H.

Hudson:
Livingstone, J. W.
Newton, J. E.
Stenberg, S. T.

Humbird:
Schwarz, S. G.

Hurley:
Bonacci, M. J.
Martinetti, D. J.

Hustisford:
Panetti, P. A.

Independence:
Peterson, C. F.
Peterson, D. R.
Walske, B. R.

Iola:
Wilker, W. F.

Janesville:
Bartels, G. W.
Baumgartner, M. M.
Clark, W. T.
Cunningham, M. A.
Danforth, H. C.
Donkle, M. J.
Farnsworth, R. W.
Frechette, F. M.
Freitag, S. A.
Gilbertsen, C. R.
Hartman, R. C.
Hatfield, M. E.
Johnson, W. L.
Keiley, J. F.
Klein, T. W.
Koch, V. W.
Kuegle, F. H.
McGuire, W. H.
Metcalf, G. S.
Munn, W. A.
Nuzum, T. O.
Nuzum, T. W.
Otterholt, E. R.
Overton, O. V.
Pember, A. H.
Schroeder, J. D.
Snodgrass, T. J.
VanKirk, F. W.
Waufle, G. C.
Welch, F. B.

Jefferson:
Brewer, J. C.
Busse, A. A.
Garding, C. J.
Robinson, A. H.

Johnson Creek:
Wendt, F. A.

Junction City:
Reis, G. W.

Juneau:
Heath, H. J.
Qualls, C. L.

Kaukauna:
Bachhuber, A. E.
Bachhuber, A. M.
Boyd, C. D.
Boyd, G. L.
Flanagan, G. J.
Hauch, F. M.
Kremers, A.
Mayer, R. G.

Kenosha:
Andre, E. F.
Ashley, T. W.
Bennett, W. H.
Binnie, Helen A.
Bowing, I. E.
Creswell, C. M.
Curtiss, F. D.
Davin, C. C.
DeFazio, S. F.
Gephart, C. H.
Graves, J. P.
Herzog, P. S.
Hill, B. S.
Kent, L. T.
Kleinpell, W. C.
Lipman, W. H.
Lokvam, L. H.
Lutz, J. J.
Mayfield, A. L.
Murphy, S. W.
Pechous, C. E.
Pechous, Lillian
Perkins, C. H.
Pifer, P. E.
Pirsch, M. V.
Randall, A. J.
Rauch, A. M.
Rauen, L. M.
Richards, C. G.
Ruffio, A. F.
Schlapik, A.
Schulte, G. C.
Schwartz, G. J.
Schwartz, H. L.
Sokow, Theodore
Stewart, W. C.
Ulrich, C. F.
Windesheim, G.
Wolf, Herman

Kewaskum:
Edwards, R. G.

Kewaunee:
Dockry, L. E.
Nesemann, R. M.
Witcpalek, E. W.
Wochos, F. J.
Wochos, W. M.

Kiel:
Knauf, F. P.
Nauth, D. F.

Kimberly:
Maes, C. G.

King:
Montgomery, R. C.

Kohler:
Cottingham, M. D.
Gascoigne, C. C.

La Crosse:
Anderson, N. P.
Anderson, P. D.
Bach, A. C.
Bannen, W. E.
Bayley, W. E.
Carlsson, E. S.
Daley, D. M.
Davies, May A.
Douglas, F. A.
Doyle, D. F.
Eagan, R. L.
Earney, L. J.
Egan, G. J.
Egan, J. F.
Eidam, L. W.
Flynn, R. E.
Fox, J. C.
Gallagher, E. E.
Gallagher, F. J.
Garrett-Bangsberg, S.
Gatterdam, P. C.
Gray, R. H.
Gundersen, A. H.
Gundersen, Gunnar
Gundersen, S. B
Gundersen, T. E.
Harman, J. C.
Heraty, J. E.
Houck, Mary Piper
Johnston, R. C.
Jones, W. J.
Lueck, G. W.
McGarty, M. A.
McLoone, J. E.
Midelfort, C. F.
Montgomery, S. A.
Reay, G. R.
Remer, W. H.
Roth, J. A.
Schneeberger, E. J.
Simones, J. J.
Sivertson, Martin
Skemp, A. A.
Skemp, G. E.
Smith, D. S.
Swarthout, Edyth C.
Townsend, E. H.
Wolf, F. H.
Wolf, H. E.

Ladysmith:
Bauer, W. B. A.
Lundmark, L. M.
O'Connor, W. F.
Pagel, H. F.
Smith, Woodruff

La Farge:
Gollin, F. F.

Lake Geneva:
Bischof, H. F.
Brady, C. J.
Halsey, R. C.
Hudson, E. D.
Jeffers, Dean
MacDonald, W. H.

Lake Mills:
Eck, G. E.
Leicht, Phillip
Peterson, M. G.
Schoenecker, E. A.
Turcott, R. A.

Lancaster:
Carey, H. W.
Fowler, J. H.
Glynn, J. D.
Godfrey, R. C.
Houghton, E. M.
Kraut, Elgie

Laona:
Carroll, G. E.
Ovitz, E. G.

LaValle:
Booher, J. A.

Lena:
Rose, J. F.

Little Chute:
Curtin, D. W.
Doyle, J. H.
Verbrick, W. C.

Lodi:
Groves, R. J.
Irwin, G. H.

Loganville:
Jewell, E. L.

Loyal:
Hable, A. P.

Luck:
Peterson, S. C.

Madison:
Aageson, C. W.
Allin, R. N.
Atwood, David
Bell, P. P.
Bennett, Maxine
Benson, R. R.
Bentley, J. E.
Birge, E. A.
Bleckwenn, W. J.
Boersma, J. J.
Bohorfoush, J. G.
Boner, A. J.
Bowman, F. F.
Brehm, P. A.
Briggs, S. J.
Brindley, B. I.
Britton, D. M.
Bryan, A. W.
Burke, C. F.
Burke, Mead
Burke, Myra E.
Burns, R. E.
Calvert, Charlotte
Cameron, Eugenia S.
Campbell, R. E.
Carns, Marie L.
Carter, H. M.
Chorlog, J. K.
Clark, Elizabeth A.
Clausen, N. M.
Clifford, J. E.
Cole, L. R.
Collins, R. F.
Connors, Angie
Cooksey, R. T.
Coon, H. M.
Cooper, G. A.
Cornwell, P. M.
Currerl, A. R.
Davis, F. A.
Davis, Helen P.
Davis, R. R.
Dean, F. K.
Dean, J. C.
Dean, J. P.
Deming, R. C.
Dickie, H. A.
Dimond, W. B.
Dollard, J. E.
Domine, A. Z.
Duehr, P. A.
Eckstam, E. E.
Ellis, I. G.
Erickson, T. C.
Evans, J. S.
Everson, L. K.
Ewell, G. H.
Fauerbach, L.
Fike, F. A.
Filek, A. A.
Finer, G. H.
Fischer, W. A.
Fosmark, C. A.
Foster, Ruth C.
Frankenstein, N. A.
Gaenslen, F. G.
Gale, J. W.
Ganser, W. J.
Gearhart, R. S.
Gehin, F. E.
Geist, F. D.
Gonce, J. E., Jr.
Gordon, E. S.
Grab, J. A. (Selective Service)
Greene, H. L.
Greiber, M. F.
Grimm, Elizabeth
Grimstad, Frances H.
Grumke, E. H.
Guilford, H. M.
Halbert, J. J.
Harper, C. A.
Harper, C. S.
Harris, J. W.
Henning, Laura E.
Henning, R. E.
Hill, N. A.
Hogben, C. A. M.
Holmgren, L. E.
Hunter, Amy Louise
Hurlbut, J. A.
Hysiop, V. B.
Jackson, A. S.
Jackson, J. A.
Jackson, Russell, Jr.
Jackson, R. H.
Jacobs, J. S.
Jaeschke, W. H.
Johnson, H. C.
Jones, W. E.
Jorris, E. H.
Juster, E. M.
Kant, Fritz
Kay, H. M.
Keck, E. B.
Keettel, W. C., Jr.
Kinney, R. J.
Krehl, W. H.
Kurtz, C. M.
Kurtz, E. C.
Kyhos, Emma D.
Lacke, C. L.
Larsen, R. B.
Lemmer, K. E.
Leonard, T. A.
Lindsay, W. T.
Littig, L. V.
Lohmiller, B. D.
Longley, B. J.
Lorenz, W. F.
Lynch, J. D.
Mahoney, Florence I.
Malec J. P.
Maloney, F. G.
Maloof, G. J.
Marsden, W. H.
Marsh, H. E.
Marshall, Helen S.
Masten, M. G.
McCormick, S. A.
McDonough, K. B.
McGary, Lester
McIntosh, R. L.
McIver, F. A.
Meanwell, W. E.
Melick, D. W.
Meyer, O. O.
Middleton, W. S.

Mings, D. E.
Mohs, F. E.
Morton, J. A.
Mowry, W. A.
Musser, M. J., Jr.
Neff, E. E.
Neller, J. L.
Nelson, E. R.
Nelson, O. O.
Nereim, T. J.
Nesbit, M. E.
Nesbit, W. M.
Neupert, C. N.
Nordby, E. J.
Okagaki, H. I.
Oosterhous, G. E.
Orth, O. S.
Ozanne, B. K.
Paul, L. W.
Pessin, Joseph
Peterson, R. K.
Pohie, E. A.
Pohie, F. J.
Pollard, W. H.
Prouty, Margaret
Puestow, K. L.
Pyre, Jackman
Quisling, A. A.
Quisling, G. D.
Quisling, R. A.
Quisling, Sverre
Radewan, M. G.
Rasmussen, N. G.
Reese, H. H.
Reuter, R. J.
Reznichek, C. G.
Ritchie, Gorton
Robbins, J. H.
Rueckert, R. R.
Schmidt, E. R.
Schmitz, R. C.
Schneiders, E. F.
Schroeder, C. F.
Schubert, C. K.
Schwittay, Addie M.
Sevringhaus, E. L.
Shapiro, H. H.
Sherman, C. F.
Shumate, J. K.
Sisk, I. R.
Smith, R. B.
Sprague, J. T.
Sprague, L. V.
Stafford, W. T.
Stebbins, G. G.
Stebbins, W. W.
Stehr, A. C.
Stewart, J. K.
Stovall, W. D.
Sullivan, A. G.
Sullivan, E. S.
Supernaw, J. S.
Swan, L. L.
Tatum, A. L.
Taylor, F. B.
Tenney, H. K.
Thelen, Christine
Thill, C. J.
Thomas, N. G.
Thornton, M. J.
Tormey, A. R.
Tormey, T. W., Jr.
Trautman, N. H.
Trautmann, M.
Urben, W. J.
Van Gemert, J. G.
Vingom, C. O.
Waddell, J. G.
Washburne, A. C.
Waters, R. M.
Wear, J. B.
Welke, E. G.
Wells, May R.
Wenger, H. A. E.
Werrell, W. A.
Weston, F. L.
Wheeler, R. M.
Wilhelm, Rosaline L.
Wilkie, J. M.
Williams, D. L.
Wilson, J. M.
Winn, H. N.
Wirlg, M. H.
Wirka, H. W.
Wynn, S. K.
Zantow, F. E.

Manawa:
Irvine, R. K.

Manitowoc:
Andrews, M. P.
Belson, H. J.
Bonner, N. A.
Donohue, W. E.
Erdmann, N. C.
Gregory, L. W.
Hammond, F. W.
Hammond, R. W.
Hoffman, G. M.
MacCollum, C. L.
Portman, R. J.
Rau, G. A.
Rauch, W. A.
Rees, T. H.
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Stueck, A. F.
Teltgen, Arthur
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Turgasen, F. E.
Wall, C. E.
Yost, R. G.

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Kampine, C. E.

Maribel:
May, J. H.

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Boren, C. H.
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Duer, G. R.
Jorgenson, H. L.
Koepp, C. E.
May, J. V.
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Baldwin, R. S.
Boeckman, F. A.
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Doege, K. H.
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Bachhuber, E. A.
Bachhuber, F. G.
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Menasha:
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Housley, H. W.
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Menomonee Falls:
Burkhardt, E. W.
Domann, W. G.
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Menomonie:
Bryant, G. E.
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Long, D. T.
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McMahon, A. E.
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Bayer, W. H.
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Crosley, G. E.
Davis, M. D.
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Milton Junction:
Vogel, T. L.

Milwaukee:
Ackerman, D. S.
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Adamkiewicz, J. J.
Adland, Abe
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Tessler, A. F.
Tharinger, E. L.
Thatcher, D. S.
Thill, G. E
Thoma, J. W.
Thompson, R. D.
Thorstensen, A. H.
Thranow, J. A.
Tillson, E. M.
Toenhart, O. E.
Tolan, T. L.
Tomkiewicz, N. O.
Torcivia, S. S.
Treskow, F. G.
Trimborn, B. A.
Troxel, J. C.
Truitt, J. W.
Tufts, Millard
Turney, C. F.
Uhley, M. H.
Unger, A. A.
Urdan, B. E.
Usow, E. J.
Usow, J. M.
Uszler, L. B.
Van de Erve, W.
Van Hecke, L. J.
Vander Linde, L. A.
Veit, Henry
Verch, L. H.
Verdone, A. J.
Wagner, P. C.
Waldeck, E. A
Waldkirch, B. P.
Waldman, I. J.
Walker, L. J.
Walton, W. B.
Warner, R. C.
Warschauer, B.
Warth, C. G.
Washburn, R. G.
Wasserman, S. E.
Watry, T. D.
Watts, Alice D.
Waxman, S. I.
Weber, A. J.
Wegmann, G. H.
Wegmann, N. J.
Weingart, W. F.
Weinshel, L. R.
Weisel, Wilson
Weisfeld, S. G.
Weisfeldt, L. A.
Weisfeldt, S. C.
Weller, R. R
Wendt, W. P.
Wenstrand, D. E. W.
Werner, D. J.
Werner, J. J.
Westhofen, R. C.
Wetzler, S. H.
Whalen, G. E.
Wiener, Kurt
Wiese, M. E. J.
Wiesen, R. P.
Wild, J. P.
Willets, J. B.
Willets, J. C.
Wilkinson, E. D.
Wilske, C. A.
Wirthweln, Carlton
Witte, D. H.
Witte, W. C. F.
Wittrock, L. H.
Wolter, S. H.
Wolters, H. F.
Wong, V. J.
Worm, G. J.
Wright, H. H.
Wyman, J. F.
Yaffe, Aaron
Yanke, A. E.
Young, A. F.
Zamil, Edward
Zaun, J. J., Jr.
Zawodny, S. E.
Zemlyn, Milton
Ziegler, C. K.
Zillmer, Helen J.
Zimmermann, B. M.
Zintek, S. S.
Zivnuska, J. F.
Zmyslony, W. P.
Zotter, H. J.
Zubatsky, D. J.
Zuercher, J. C.
Zurheide, H. O.

Mineral Point:
Ludden, H. D.
Ridley, S. R.

Minocqua:
Huber, G. W.
Sprague, J. P.
Torpy, T. G.

Mishicot:
Skwor, C. J.

Mondovi:
Gillette, F. J.
Johnson, B. F.
Sharp, D. S.

Monroe:
Baumle, C. E.
Bear, N. E.
Bear, W. G.
Bristow, J. H.
Creasy, L. E.
Fillbach, H. E.
Gnagi, W. B., Jr.
Kindschi, L. G.
Kundert, F. W.
Moore, L. A.
Ruehlman, D. D.
Schindler, J. A.

Montello:
Inman, R. F.

Montfort:
Moffett, J. L.

Montreal:
Baird, H. D.
Pierpont, J. M.

Mosinee:
Butler, E. F.
Jackson, J. A.
Jorgensen, P. B.

Mount Calvary:
Baasen, J. M.
Miller, J. F.

Mount Horeb:
Kjervik, A. R.
Morrison, M. A.

Mukwonago:
Kern, E. E.
Purdy, F. P.
Voellings, W. J.

Muscoda:
Ackerman, E. T.
Klockow, W. E.

Muskego:
Kelm, G. J.

Neenah:
Anderson, G. R.
Baxter, H. L.
Beglinger, H. F.
Brown, R. C.
Brunckhorst, F. O.
Canavan, J. P.
Foseid, O. F.
Graham, A. P.
Lowe, R. C.
Moon, R. A.
Petersen, G. W.
Pitz, M. N.
Quade, R. H.
Regan, D. M.
Smith, T. D.
Williamson, G. H.

Neillsville:
Frank, H. A.
Frank, J. H.
Overman, M. V.

Nekoosa:
Backus, O. A.
Pomainville, H. G.

Newburg:
Weber, H. F.

New Franken:
Looze, J. A.

New Glarus:
Francois, S. J. A.
Hicks, E. V.

New Holstein:
Engel, A. C.

New Lisbon:
Starnes, Brand

New London:
Borchardt, M. A.
Dernbach, G. P.
Monsted, J. W.
Pfeifer, F. J.
Schmallenberg, H. C.

New Richmond:
Armstrong, J. H.
Drury, E. M.
Epley, O. H.

Niagara:
McCormack, Edward

Oconomowoc:
Feasler, C. H.
Giffin, J. S.
Hassall, J. C.
James, W. D.
Loughnan, A. J.
Love, G. R.
Morrison, D. A. R.
Nammacher, T. H.
Stemper, I. T.
Theobald, P. B.
Wilkinson, D. C.
Wilkinson, J. D.
Wilkinson, J. F.
Wilkinson, M. R.

Oconto:
Aageson, H. A.
Kwapy, C. R.
Slaney, A. F.

Oconto Falls:
Goggins, R. J.
Krahn, G. W.
Ohswaldt, H. F.
Rauchschwalbe, L. E.

Ogema:
Rinehart, B. M.

Omro:
Schoenbechler, L. J.

Onalaska:
Reay, G. D.

Ontario:
Devine, G. C.

Oostburg:
Van Zanten, Wm.

Oregon:
Johnson, E. S.
Joyner, T. H.

Orfordville:
McNair, E. R.

Osceola:
Jeronimus, H. J., Jr.
Simenstad, L. O.

Oshkosh:
Baier, A. R.
Beatty, S. R.
Bitter, R. H.
Clark, Burton
Clark, W. E.
Connell, F. G.
Cummings, E. F.
Danforth, H. J.
Danforth, Q. H.
Ebert, R. O.
Emrich, P. S.
Haines, M. C.
Haubrick, H. J.
Helmes, L. O.
Hogan, J. M.
Hugo, D. G.
Ihrke, I. A.
Kleinschmit, H. W.
Koehler, A. G.
Kronzer, J. J.
Kuhn, R. V.
Lee, H. J.
Leibenson, S. J.
Linn, W. N.
Lockhart, J. W.
Lynch, G. V.
Meilicke, C. A.
Meli, J. V.
Mendez, A. A.
Meusel, H. H.
Owen, G. C.
Pfefferkorn, E. B.
Romberg, H. A.
Scheln, J. E.
Steele, G. A.
Steen, M. H.
Stein, J. F.
Wagner, R. F.
Wagner, W. A.
Wheeler, W. P.
Williams, E. B.
Wright, P. E.

Osseo:
Knutson, O.
Leasum, R. N.

Owen:
Dike, B. H.

Palmyra:
Bertolaet, E. E.

Pardeeville:
Gillette, H. E.

Park Falls:
Leahy, J. D.
Murphy, J. L.
Riley, E. A.

Pepin:
Belitz, A. E.
Hogan, John

Peshtigo:
Bell, J. M.
Haasl, H. W.

Pewaukee:
Egloff, L. W.
Kelly, J. P.

Phillips:
Norviel, H. B.
Rens, J. L.
Van Hecke, D. S.

Pittsville:
Beyer, Hart
Glenn, E. C.

Plain:
Fowler, P. H.

Plainfield:
Ingersoll, R. S.

Platteville:
Andrew, C. H.
Cunningham, Wilson
Doeringsfeld, H. L.
Schuldt, C. M.
Soles, F. A.
Stoops, C. W.
Wheeler, C. H. E.

Plum City:
Steiger, E. E.

Plymouth:
Brickbauer, A. J.
Deicher, H. F.
Hill, F. A.
Limberg, P. W.
Mueller, J. F.
Radloff, A. C.
Sieker, A. W.
Yoran, C. M.

Portage:
Harkins, J. P.
Henney, C. W.
MacGregor, J. W.
Saxe, J. J.
Snyder, K. A.
Taylor, W. A.
Tierney, E. F.

Port Washington:
Barr, Arnold
Drissen, W. H.
Kauth, C. P.
Pomeroy, R. K.
Regner, M. F.
Stein, C. C.

Potosi:
Kelly, W. J.

Pound:
Pelkey, R. B.

Poynette:
Dryer, R. B.
Focke, W. J.

Prairie du Chien:
Dessloch, E. M.
Farrell, J. J.
Farrell, T. S.
Kane, J. J.
Kleinpell, H. H.
Lechtenberg, E. H.
Milchen, Carl
Satter, O. E.
Shapiro, H. L.

Prairie du Sac:
Hannan, K. D. L.

Prentice:
MacKinnon, G. E.

Prescott:
Laney, H. J.

Pulaski:
Gallette, L. E.
Goggins, J. R.
Shippy, V. J.

Racine:
Adamski, A. W.
Albino, J. M.
Brehm, H. G.
Brehm, H. J.
Buckley, W. E.
Christensen, F. C.
Constantine, C. E.
Covell, K. W.
Docter, J. C.
Faber, S. J.
Fazen, L. E.
Fazen, L. E., Jr.
Gillett, G. N.
Gosman, J. A.
Hahn, C. K.
Hahn, P. R.
Hanson, W. C.
Hemmingsen, T. C.
Henken, J. F.
Hilker, H. C.
Hogan, J. H.
Howe, H. W.
Jacks, R. R.
Jones, Beatrice O.
Kehl, K. C.
Keland, H. B.
Kline, C. L.
Konnak, Wm. F.
Kreul, R. W.
Kreul, W. R.
Kurten, R. M.
Lehner, R. H.
Lifschutz, L. M.
Lindner, A. M.
Marek, F. B.
Miller, H. C.
Nelson, A. L.
Peterson, R. O.
Pfeffer, T. J.
Pfeifer, E. C.
Pfeiffer, A. S.
Pfeiffer, O. W.
Pope, F. W.
Postorino, J. D.
Rodick, J. C.
Roth, W. C.
Rothenmaier, G. L.
Schacht, E. W.
Schacht, R. J.
Schaefer, C. O.
Schenkenberg, Grace E.
Schneller, E. J.
Schnetz, L. N.
Thackeray, R. C.
Thompson, I. F.
Tucker, I. N.
von Buddenbrock, E.
von Jarchow, B. L.
Wagner, N. B.
Walter, G. W.
Walters, H. G.
Wier, F. A.
Wright, R. S.

Randolph:
Jones, A. W.
Vetter, E. W.

Random Lake:
Malloy, T. E.
Russell, J. A.

Red Granite:
Darby, R. C.

Reedsburg:
Hanko, J. E.
Pawlisch, O. V.
Rouse, J. J.
Sporleder, O. F.
Stadel, E. V.
Stanton, E. D.

Reedsville:
Cary, E. C.

Rhinelander:
Bump, W. S.
Cline, Frances A.
Gager, W. F.
Harter, A. F.
Komasinski, V. W.
Richards, C. A.
Schiek, I. E.
Schiek, I. E., Jr.
Wright, Marvin

Rib Lake:
Horn, A. S.

Rice Lake:
Dawson, D. L.
Rydell, O. E.
Rydell, W. B.

Richfield:
Kern, T. J.

Richland Center:
Benson, G. B.
Benson, G. H.
Brown, R. J.
Davis, L. C.
Dull, C. F.
Edwards, W. C.
Housner, R. E.
Parke, George, Jr.
Pippin, B. I.
Sholtes, C. A.
Solberg, Marvin
Taft, D. J.

Rio:
Maas, W. C.
Pease, W. A.

Ripon:
Bachus, A. C.
Barnes, E. C.
Cole, D. F.
Hazeltine, C. P.
Johnson, J. M.
Jones, R. H.
La Ham, J. T.
O'Neal, Orvil
Senn, C. U.
Watson, E. L.

River Falls:
Cairns, R. U.
Davee, Chalmer
Dawson, C. A.
McJilton, C. E. J.

Roberts:
Ford, A. M.

Rosendale:
Scheid, M. M.

Rosholt:
Benn, V. A.

St. Cloud:
Kief, H. J.

St. Croix Falls:
Riegel, J. A.

St. Nazianz:
Foley, M. E.

Sauk City:
Bachhuber, H. A.
Walsh, T. W.

Sawyer:
Olsen, W. J.

Seneca:
Hammes, G. R.

Seymour:
Groendahl, R. C.
Hittner, V. J.
Sieb, L. H.

Sharon:
Treat, C. R.
Warrick, J. D.

Shawano:
Bauer, Frederick
Cantwell, A. A.
Cantwell, R. C.
Marsh, H. C.
Peterson, L. W.
Schutz, W. J.
Sebesta, A. J.
Stubenvoll, C. E.

Sheboygan:
Bock, A. B. C.
Eigenberger, F.
Fiedler, O. A.
Genter, A. E.
Glaubitz, B. J.
Greenstein, Carl
Gruenwald, Ludwig
Gunther, T. J.
Heiden, H. H.
Hildebrand, G. J.
Hougen, E. T.
Huibregtse, W. G.
Juckem, G. J.

Junck, J. A.
Knauf, A. J.
Knauf, G. E.
Kolb, F. K.
Kovacic, J. F.
Mason, P. B.
McRoberts, J. W.
Meier, Wm. G.
Nause, F. A., Jr.
Neu, V. F.
Neumann, W. H.
O'Donnell, S. P.
Pauly, L. F.
Scheer, G. H.
Schmitt, A. J.
Schott, E. G.
Simonson, L. M.
Sonnenburg, W. M.
Squire, C. A.
Tasche, C. T.
Tasche, J. A.
Tasche, L. W.
Van Zanten, Wesley
Weber, C. J.
Zaegel, R. L.

Sheboygan Falls:
Hansen, H. J.
Leighton, F. A.
Pfeiler, A. G.

Shell Lake:
Moen, D. V.

Shiocton:
LaCroix, G. M.

Shullsburg:
Gratiot, Mary P.
Hoesley, H. F.
Van Ells, L. A.

Silver Lake:
De Witt, C. A.

Siren:
Duerr, Eleanor E.
Sherman, L. F.

Slinger:
Prefontaine, K. F.

Soldiers Grove:
Sannes, W. A.

Solon Springs:
Wilcox, A. G.

South Milwaukee:
Crigler, R. R.
Dempsey, G. P.
Flaherty, G. S.
Oberfeld, H. H.
O'Leary, W. J.
Rumph, C. L.
Sickels, W. A.

Sparta:
Beebe, D. C.
Beebe, S. D.
Mannis, Harry
Phalen, C. S.
Scantleton, J. M.
Williams, H. H., Jr.
Williams, H. H., Sr.

Spencer:
Callahan, H. T.

Spooner:
Lemmer, G. N.
Muccilli, A. E.

Spring Green:
Nee, Frank
Wahl, C. M.

Spring Valley:
Conway, H. P.
Conway, J. M.

Stanley:
Graber, R. E.
Overgard, A. W.

Star Prairie:
Perrin, H. E.

Statesan:
Schmidt, R. H.

Stevens Point:
Anderson, G. H.
Anderson, H. A.
Bonn, H. P.
Cowan, W. F.
Crosby, E. P.
Dunn, A. G.
Gramowski, W. A.
Iber, F. C.
Kidder, E. E.
Krembs, F. R.
Litzow, J. A.
Marrs, F. A.
Miller, S. R.
Rice, M. G.
Rice, R. W.
Sheehan, W. C.
Slater, R. H.
Sowka, P. N.
Wisiol, Erich

Stockbridge:
Knauf, J. A.

Stoughton:
Keenan, H. A.
Olson, A. L.
Schoenbeck, R. F.
Smedal, A. T.

Stratford:
Kroeplin, F. C.

Strum:
Winter, E. F.

Sturgeon Bay:
Beck, J. G.
Dorchester, D. E.
Grota, H. D.
Huff, F. C.
Muehlhauser, J. O.

Sturtevant:
Peehn, F. G.

Sun Prairie:
Barnstein, N. J.
McCabe, J. M.
Nelson, E. J.
Paulson, J. F.
Peterson, L. W.

Superior:
Averbook, M. S.
Beebe, L. W.
Carpenter, E. E.
Christiansen, C. H.
Christiansen, R. E.
Christianson, H. B.
Doyle, T. J.
Droege, C. T.
Ekblad, V. E.
Finn, Milton
Fruehauf, R. P.
Giesen, Charles W.
Giesen, Conrad W.
Goodfellow, J. R.
Ground, W. E.
Hathaway, G. J.
Jerome, Bourne
Johnson, F. G., Jr.
Kyllo, J. C.
Lavine, M. M.
Mason, C. H.
McGill, J. W.
Meyers, J. M.
Myers, E. A.
Orchard, H. J.
Perrin, S. H.
Picard, C. J.
Schnell, W. H.
Searle, D. R.
Sincock, H. A.
Wall, M. H.
Weisberg, J. H.

Suring:
Dougherty, J. S.

Sussex:
Van Valin, E. C.

Theresa:
Langenfeld, G. P.
Langenfeld, P. F.

Thiensville:
Carthaus, A. H. C.
Elbe T. D.
Scholz, H. F.

Thorp:
Neis, F. P.

Tigerton:
Gates, A. J.

Tomah:
Bell, A. R.
Cremer, V. H.
Scheurich, L. G.
Winter, A. E.

Tomahawk:
Baker, G. R.
Baker, R. G.
McCormick, W. C.

Turtle Lake:
Shima, R. T.

Two Rivers:
Kozelka, A. W.
Martin, R. E.
Moriarty, L. J.
Weld, S. L.
Zlatnik, A. P.

Union Grove:
Atherton, C. C.
Burst, Wm.
McCracken, R. W.
Schulz, G. J.

Valders:
Huth, E. W.

Verona:
Weiland, H. P.

Viola:
Morrow, C. A.
Parke, George

Viroqua:
Gulbrandsen, H.
Gulbrandsen, L. F.
Hirsch, R. S.
Kuehn, A. E.
Ludden, R. H.
Martin, S. J.
Trowbridge, W. M.

Wabeno:
Tenley, O. S.

Walworth:
Coon, W. W.
Kroyer, T. J.

Washburn:
Juhl, John H.

Waterford:
Dietz, R. J.
Malone, F. A.
Wigod, David

Waterloo:
Allen, S. C.

Watertown:
Abelmann, T. C. H.
Becker, W. C.
Bowen, E. W.
Bowen, H. P.
Burzynski, E. E.
Dierker, O. F.
Hahn, A. C.
Haney, F. C.
Kosanke, F. E.
Mallow, H. G. E.
Miller, E. A.
Nickels, A. C.
Nowack, L. H.
Nowack, L. W.
Waite, W. S.
Zimmermann, F. H.

Waukesha:
Campbell, P. E.
Campbell, W. B.
Christianson, James
Davies, E. B.
Davies, Gwilym
Davies, R. E.
Edmondson, C. C.
Frick, J. C.
Gantz, H. A.
Hamernik, F. J.
Howe, G. E.
Lochen, E. L.
Scheele, F. M.
Settlage, H. A.
Sydow, H. F.
Tibbitts, U. J.
Werra, M. J.
Williams, A. J.
Wood, C. A.
Woodhead, F. J.
Zietlow, F. G.

Waunakee:
Marquis, W. R.

Waupaca:
Boudry, M. O.
Breckenridge, H. E.
Christofferson, A. M.
Christofferson, J. W.
Patterson, L. G.
Salan, Sam

Waupun:
Clark, F. T.
Hebenstreit, A. J.
Klepfer, J. F.
Remley, A. R.
Reslock, C. P.
Schmidt, E. A.
Schrank, R. E.
Swartz, K. A.

Wausau:
Boslough, A. W.
Brick, E. B.
Burek, A. W.
Christensen, H. H
Christensen, H. W.
Crawford, Helen L.
Fechtner, H. H.
Fehland, H. R.
Flannery, J. V.
Flemming, E. E.
Freeman, J. M.
Frenzel, W. C.
Green, D. M.
Jones, M. L.
Juers, R. H.
Ludwig, E. P.
Macaulay, E. M.
Martini, H. F.
Prehn, F. C.
Reist, P. Z.
Smith, J. F.
Smith, S. M. B.
Stahmer, A. H.
Stevens, G. H.
Trumbo, J. K.
Wilson, O. M.

Wausaukee:
Rose, J. M.

Wautoma:
Beck, A. A.
Karnopp, G. L.

Wauwatosa:
Baird, Katherine H.
Banyai, A. L.
Benjamin, H. B.
Boyce, D. C.
Cadden, A. V.
Charles, J. D.
Cordes, V. J.
Currer, P. R.
Cutler, J. S.
Dallwig, E. L.
Daniels, E. R.
Dettmann, N. F.
Deysach, L. J.
Fellows, R. M.
Fifrick, L. L.
Gates, J. F.
Goldberger, E. W.
Gramling, E. H.
Hansen, R. T.
Hershberg, R. A.
Hoffman, C. W.
Howard, M. Q.
Janney, F. R.
Judd, R. W.
Jurgens, G. H.
Kasak, Michael
Kehlnhofer, F. H.
Kindwall, J. A.
Klieger, J. A.
Kocovsky, E. C.
Kradwell, W. T.
Kuzma, J. F.
Leifert, K. A.
Morrison, R. C.
Osgood, C. W.
Peterson, E. F.
Prout, F. J.
Ramlow, L. W.
Rettig, F. E.
Roberts, H. M.
Ruskin, B. A.
Sakaguchi, S. S.
Sargeant, H. W.
Schlueter, F. E.
Schmidt, E. C.
Seymer, L. A.
Shabart, E. J.
Wick, Samuel
Wilkinson, P. M.
Winters, K. J.
Wynegar, D. E.

Webster:
Maas, David

West Allis:
Biljan, M. W.
Black, S. B.
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Principles of Medical Ethics of the American Medical Association

CHAPTER I

IN GENERAL

THE PHYSICIAN'S RESPONSIBILITY

SECTION 1.—A profession has for its prime object the service it can render to humanity; reward or financial gain should be a subordinate consideration. The practice of medicine is a profession. In choosing this profession an individual assumes an obligation to conduct himself in accord with its ideals.

GROUPS AND CLINICS

SEC. 2.—The ethical principles actuating and governing a group or clinic are exactly the same as those applicable to the individual. As a group or clinic is composed of individual doctors each of whom whether employer, employee or partner, is subject to the principles of ethics herein elaborated, the uniting into a business or professional organization does not relieve them either individually or as a group from the obligation they assume when entering the profession.

CHAPTER II

THE DUTIES OF PHYSICIANS TO THEIR PATIENTS

PATIENCE, DELICACY AND SECRECY

SECTION 1.—Patience and delicacy should characterize all the acts of a physician. The confidences concerning individual or domestic life entrusted by a patient to a physician and the defects of disposition or flaws of character observed in patients during medical attendance should be held as a trust and should never be revealed except when imperatively required by the laws of the state. There are occasions, however, when a physician must determine whether or not his duty to society requires him to take definite action to protect a healthy individual from becoming infected, because the physician has knowledge, obtained through the confidences entrusted to him as a physician, of a communicable disease to which the healthy individual is about to be exposed. In such a case, the physician should act as he would desire another to act toward one of

his own family under like circumstances. Before he determines his course, the physician should know the civil law of his commonwealth concerning privileged communications.

PROGNOSIS

SEC. 2.—A physician should give timely notice of dangerous manifestations of the disease to the friends of the patient. He should neither exaggerate nor minimize the gravity of the patient's condition. He should assure himself that the patient or his friends have such knowledge of the patient's condition as will serve the best interests of the patient and the family.

PATIENTS MUST NOT BE NEGLECTED

SEC. 3.—A physician is free to choose whom he will serve. He should, however, always respond to any request for his assistance in an emergency or whenever temperate public opinion expects the service. Once having undertaken a case, a physician should not abandon or neglect the patient because the disease is deemed incurable; nor should he withdraw from the case for any reason until a sufficient notice of a desire to be released has been given the patient or his friends to make it possible for them to secure another medical attendant.

CHAPTER III

THE DUTIES OF PHYSICIANS TO EACH OTHER AND TO THE PROFESSION AT LARGE

ARTICLE I.—DUTIES TO THE PROFESSION

UPHOLD HONOR OF PROFESSION

SECTION 1.—The obligation assumed on entering the profession requires the physician to comport himself as a gentleman and demands that he use every honorable means to uphold the dignity and honor of his vocation, to exalt its standards and to extend its sphere of usefulness. A physician should not base his practice on an exclusive dogma or sectarian system, for "sects are implacable despots; to accept their thraldom is to take away all liberty from one's action and thought." (Nicon, father of Galen.)

MEDICAL SOCIETIES

SEC. 2.—In order that the dignity and honor of the medical profession may be upheld, its standards exalted, its sphere of usefulness extended, and the advancement of medical science promoted, a physician should associate himself with medical societies and contribute his time, energy and means in order that these societies may represent the ideals of the profession.

DEPORTMENT

SEC. 3.—A physician should be "an upright man, instructed in the art of healing." Consequently, he must keep himself pure in character and conform to a high standard of morals, and must be diligent and conscientious in his studies. "He should also be modest, sober, patient, prompt to do his whole duty without anxiety; pious without going so far as superstition, conducting himself with propriety in his profession and in all the actions of his life." (Hippocrates.)

ADVERTISING

SEC. 4.—Solicitation of patients by physicians as individuals, or collectively in groups by whatsoever name these be called, or by institutions or organizations, whether by circulars or advertisements, or by personal communications, is unprofessional. This does not prohibit ethical institutions from a legitimate advertisement of location, physical surroundings and special class—if any—of patients accommodated. It is equally unprofessional to procure patients by indirection through solicitors or agents of any kind, or by indirect advertisement, or by furnishing or inspiring newspaper or magazine comments concerning cases in which the physician has been or is concerned. All other like self-laudations defy the traditions and lower the tone of any profession and so are intolerable. The most worthy and effective advertisement possible, even for a young physician, and especially with his brother physicians, is the establishment of a well-merited reputation for professional ability and fidelity. This cannot be forced, but must be the outcome of character and conduct. The publication or circulation of ordinary simple business cards, being a matter of personal taste or local custom, and sometimes of convenience, is not *per se* improper. As implied, it is unprofessional to disregard local customs and offend recognized ideals in publishing or circulating such cards.

It is unprofessional to promise radical cures; to boast of cures and secret methods of treatment or remedies; to exhibit certificates of skill or of success in the treatment of diseases; or to employ any methods to gain the attention of the public for the purpose of obtaining patients.

PATENTS AND PERQUISITES

SEC. 5.—It is unprofessional to receive remuneration from patents or copyrights on surgical instruments, appliances, medicines, foods, methods or procedures. It is equally unprofessional by ownership or control of patents or copyrights either to retard or to inhibit research or to restrict the benefit to patients or to the public to be derived therefrom. It is unprofessional to accept rebates on prescriptions or appliances, or perquisites from attendants who aid in the care of patients.

MEDICAL LAWS—SECRET REMEDIES

SEC. 6.—It is unprofessional for a physician to assist unqualified persons to evade legal restrictions governing the practice of medicine; it is equally un-

ethical to prescribe or dispense secret medicines or other secret remedial agents, or manufacture or promote their use in any way.

SAFEGUARDING THE PROFESSION

SEC. 7.—Physicians should expose without fear or favor, before the proper medical or legal tribunals, corrupt or dishonest conduct of members of the profession. All questions affecting the professional reputation or standing of a member or members of the medical profession should be considered only before proper medical tribunals in executive sessions or by special or duly appointed committees on ethical relations. Every physician should aid in safeguarding the profession against the admission to its ranks of those who are unfit or unqualified because deficient either in moral character or education.

ARTICLE II.—PROFESSIONAL SERVICES OF PHYSICIANS TO EACH OTHER

PHYSICIANS DEPENDENT ON EACH OTHER

SECTION 1.—Experience teaches that it is unwise for a physician to treat members of his own family or himself. Consequently, a physician should always cheerfully and gratuitously respond with his professional services to the call of any physician practicing in his vicinity, or of the immediate family dependents of physicians.

COMPENSATION FOR EXPENSES

SEC. 2.—When a physician from a distance is called on to advise another physician or one of his family dependents, and the physician to whom the service is rendered is in easy financial circumstances, a compensation that will at least meet the traveling expenses of the visiting physician should be proffered. When such a service requires an absence from the accustomed field of professional work of the visitor that might reasonably be expected to entail a pecuniary loss, such loss should, in part at least, be provided for in the compensation offered.

ONE PHYSICIAN TO TAKE CHARGE

SEC. 3.—When a physician or a member of his dependent family is seriously ill, he or his family should select a physician from among his neighboring colleagues to take charge of the case. Other physicians may be associated in the care of the patient as consultants.

ARTICLE III.—DUTIES OF PHYSICIAN IN CONSULTATIONS

CONSULTATIONS SHOULD BE ENCOURAGED

SECTION 1.—In serious illness, especially in doubtful or difficult conditions, the physician should request consultations.

CONSULTATION FOR PATIENT'S BENEFIT

SEC. 2.—In every consultation, the benefit to be derived by the patient is of first importance. All the physicians interested in the case should be frank and candid with the patient and his family. There never is occasion for insincerity, rivalry or envy and these should never be permitted between consultants.

PUNCTUALITY

SEC. 3.—It is the duty of a physician, particularly in the instance of a consultation, to be punctual in attendance. When, however, the consultant or the physician in charge is unavoidably delayed, the one who first arrives should wait for the other for a reasonable time, after which the consultation should be considered postponed. When the consultant has come from a distance, or when for any reason it will be difficult to meet the physician in charge at another time, or if the case is urgent, or if it be the desire of the patient, he may examine the patient and mail his written opinion, or see that it is delivered under seal, to the physician in charge. Under these conditions, the consultant's conduct must be especially tactful; he must remember that he is framing an opinion without the aid of the physician who has observed the course of the disease.

PATIENT REFERRED TO SPECIALIST

SEC. 4.—When a patient is sent to one specially skilled in the care of the condition from which he is thought to be suffering, and for any reason it is impracticable for the physician in charge of the case to accompany the patient, the physician in charge should send to the consultant by mail, or in the care of the patient under seal, a history of the case, together with the physician's opinion and an outline of the treatment, or so much of this as may possibly be of service to the consultant; and as soon as possible after the case has been seen and studied, the consultant should address the physician in charge and advise him of the results of the consultant's investigation of the case. Both these opinions are confidential and must be so regarded by the consultant and by the physician in charge.

DISCUSSIONS IN CONSULTATION

SEC. 5.—After the physicians called in consultation have completed their investigations of the case, they should meet by themselves to discuss conditions and determine the course to be followed in the treatment of the patient. No statement or discussion of the case should take place before the patient or friends, except in the presence of all the physicians attending or by their common consent; and no opinions or prognostications should be delivered as a result of the deliberations of the consultants, which have not been concurred in by the consultants at their conference.

ATTENDING PHYSICIAN RESPONSIBLE

SEC. 6.—The physician in attendance is in charge of the case and is responsible for the treatment of the patient. Consequently, he may prescribe for the patient at any time and is privileged to vary the mode of treatment outlined and agreed on at a consultation whenever, in his opinion, such a change is warranted. However, at the next consultation, he should state his reasons for departing from the course decided on at the previous conference. When an emergency occurs during the absence of the attending physician, a consultant may provide for the emergency and the subsequent care of the patient until the arrival of the physician in charge, but should do no more than this without the consent of the physician in charge.

CONFLICT OF OPINION

SEC. 7.—Should the attending physician and the consultant find it impossible to agree in their view of a case another consultant should be called to the conference or the first consultant should withdraw. However, since the consultant was employed by the patient in order that his opinion might be obtained, he should be permitted to state the result of his study of the case to the patient, or his next friend in the presence of the physician in charge.

CONSULTANT AND ATTENDANT

SEC. 8.—When a physician has attended a case as a consultant, he should not become the attendant of the patient during that illness except with the consent of the physician who was in charge at the time of the consultation.

ARTICLE IV.—DUTIES OF PHYSICIANS IN CASES OF INTERFERENCE

MISUNDERSTANDINGS TO BE AVOIDED

SECTION 1.—The physician, in his intercourse with a patient under the care of another physician, should observe the strictest caution and reserve; should give no disingenuous hints relative to the nature and treatment of the patient's disorder; nor should the course of conduct of the physician, directly or indirectly, tend to diminish the trust reposed in the attending physician. In embarrassing situations, or wherever there may seem to be a possibility of misunderstanding with a colleague, the physician should always seek a personal interview with his fellow.

SOCIAL CALLS ON PATIENT OF ANOTHER PHYSICIAN

SEC. 2.—A physician should avoid making social calls on those who are under the professional care of other physicians without the knowledge and consent of the attendant. Should such a friendly visit be made, there should be no inquiry relative to the nature of the disease or comment upon the treatment of the case, but the conversation should be on subjects other than the physical condition of the patient.

SERVICES TO PATIENT OF ANOTHER PHYSICIAN

SEC. 3.—A physician should never take charge of or prescribe for a patient who is under the care of another physician, except in an emergency, until after the other physician has relinquished the case or has been properly dismissed.

CRITICISM TO BE AVOIDED

SEC. 4.—When a physician does succeed another physician in the charge of a case, he should not make comments on or insinuations regarding the practice of the one who preceded him. Such comments or insinuations tend to lower the esteem of the patient for the medical profession and so react against the critic.

EMERGENCY CASES

SEC. 5.—When a physician is called in an emergency and finds that he has been sent for because the family attendant is not at hand, or when a physician is asked to see another physician's patient because of an aggravation of the disease, he should provide only for the patient's immediate need and should withdraw from the case on the arrival of the family physician after he has reported the condition found and the treatment administered.

WHEN SEVERAL PHYSICIANS ARE SUMMONED

SEC. 6.—When several physicians have been summoned in a case of sudden illness or of accident the first to arrive should be considered the physician in charge. However, as soon as the exigencies of the case permit, or on the arrival of the acknowledged family attendant or the physician the patient desires to serve him, the first physician should withdraw in favor of the chosen attendant; should the patient or his family wish some one other than the physician known to be the family physician to take charge of the case the patient should advise the family physician of his desire. When, because of sudden illness or accident, a patient is taken to a hospital, the patient should be returned to the care of his known family physician as soon as the condition of the patient and the circumstances of the case warrant this transfer.

A COLLEAGUE'S PATIENT

SEC. 7.—When a physician is requested by a colleague to care for a patient during his temporary absence, or when, because of an emergency, he is asked to see a patient of a colleague, the physician

should treat the patient in the same manner and with the same delicacy as he would have one of his own patients cared for under similar circumstances. The patient should be returned to the care of the attending physician as soon as possible.

RELINQUISHING PATIENT TO REGULAR ATTENDANT

SEC. 8.—When a physician is called to the patient of another physician during the enforced absence of that physician, the patient should be relinquished on the return of the latter.

SUBSTITUTING IN OBSTETRIC WORK

SEC. 9.—When a physician attends a woman in labor in the absence of another who has been engaged to attend, such physician should resign the patient to the one first engaged, upon his arrival; the physician is entitled to compensation for the professional services he may have rendered.

ARTICLE V.—DIFFERENCES BETWEEN PHYSICIANS

ARBITRATION

SECTION 1.—Whenever there arises between physicians a grave difference of opinion which cannot be promptly adjusted, the dispute should be referred for arbitration to a committee of impartial physicians, preferably the Board of Censors of a component county society of the American Medical Association.

ARTICLE VI.—COMPENSATION

LIMITS OF GRATUITOUS SERVICE

SECTION 1.—The poverty of a patient and the mutual professional obligation of physicians should command the gratuitous services of a physician. But endowed institutions and organizations for mutual benefit, or for accident, sickness and life insurance, or for analogous purposes, have no claim upon physicians for unremunerated services.

CONDITIONS OF MEDICAL PRACTICE

SEC. 2.—It is unprofessional for a physician to dispose of his services under conditions that make it impossible to render adequate service to his patient or which interfere with reasonable competition among the physicians of a community. To do this is detrimental to the public and to the individual physician, and lowers the dignity of the profession.

CONTRACT PRACTICE

SEC. 3.—By the term "contract practice" as applied to medicine is meant the carrying out of an agreement between a physician or a group of physicians, as principals or agents, and a corporation, organization, political subdivision or individual, to furnish partial or full medical services to a group or class of individuals on the basis of a fee schedule, or for a salary or a fixed rate per capita.

Contract practice *per se* is not unethical. However, certain features or conditions if present make a contract unethical, among which are: (1) When there is solicitation of patients, directly or indirectly. (2) When there is underbidding to secure the contract. (3) When the compensation is inadequate to assure good medical service. (4) When there is interference with reasonable competition in a community. (5) When free choice of a physician is prevented. (6) When the conditions of employment make it impossible to render adequate service to the patients. (7) When the contract because of any of its provisions or practical results is contrary to sound public policy. The phrase "free choice of physician," as applied to contract practice, is defined to mean that degree of freedom in choosing a physician which can be exercised under usual conditions of employment between patient and physician when no third party has a valid interest or intervenes. The interjection of a third party who has a valid interest or who intervenes does not *per se* cause a contract to be unethical. A "valid interest" is one where, by law or necessity, a third party is legally responsible either for cost of care or for indemnity. "Intervention" is the voluntary assumption of partial or full financial responsibility for medical care. Intervention shall not proscribe endeavor by component or constituent medical societies to maintain high quality of service rendered by members serving under approved sickness service agreements between such societies and governmental boards or bureaus and approved by the respective societies.

Each contract should be considered on its own merits and in the light of surrounding conditions. Judgment should not be obscured by immediate, temporary or local results. The decision as to its ethical or unethical nature must be based on the ultimate effect for good or ill on the people as a whole.

COMMISSIONS

SEC. 4.—When a patient is referred by one physician to another for consultation or for treatment, whether the physician in charge accompanies the patient or not, it is unethical to give or to receive a commission by whatever term it may be called or under any guise or pretext whatsoever.

DIRECT PROFIT TO LAY GROUPS

SEC. 5.—It is unprofessional for a physician to dispose of his professional attainments or services to any lay body, organization, group or individual, by whatever name called, or however organized, under

terms or conditions which permit a direct profit from the fees, salary, or compensation received to accrue to the lay body or individual employing him. Such a procedure is beneath the dignity of professional practice, is unfair competition with the profession at large, is harmful alike to the profession of medicine and the welfare of the people, and is against sound public policy.

CHAPTER IV

THE DUTIES OF THE PROFESSION TO THE PUBLIC

PHYSICIANS AS CITIZENS

SECTION 1.—Physicians, as good citizens and because their professional training specially qualifies them to render this service, should give advice concerning the public health of the community. They should bear their full part in enforcing its laws and sustaining the institutions that advance the interests of humanity. They should cooperate especially with the proper authorities in the administration of sanitary laws and regulations. They should be ready to counsel the public on subjects relating to sanitary police, public hygiene and legal medicine.

PUBLIC HEALTH

SEC. 2.—Physicians, especially those engaged in public health work, should enlighten the public regarding quarantine regulations; on the location, arrangement and dietaries of hospitals, asylums, schools, prisons and similar institutions; and concerning measures for the prevention of epidemic and contagious diseases. When an epidemic prevails, a physician must continue his labors for the alleviation of suffering people, without regard to the risk to his own health or life or to financial return. At all times, it is the duty of the physician to notify the properly constituted public health authorities of every case of communicable disease under his care, in accordance with the laws, rules and regulations of the health authorities of the locality in which the patient is.

PUBLIC WARNED

SEC. 3.—Physicians should warn the public against the devices practiced and the false pretentions made by charlatans which may cause injury to health and loss of life.

PHARMACISTS

SEC. 4.—By legitimate patronage, physicians should recognize and promote the profession of pharmacy; but any pharmacist, unless he be qualified as a physician, who assumes to prescribe for the sick, should be denied such countenance and support. Moreover, whenever a druggist or pharmacist dispenses deteriorated or adulterated drugs, or substitutes one remedy for another designated in a prescription, he thereby forfeits all claims to the favorable consideration of the public and physicians.

CONCLUSION

While the foregoing statements express in a general way the duty of the physician to his patients, to other members of the profession and to the profession at large, as well as of the profession to the public, it is not to be supposed that they cover the whole field of medical ethics, or that the physician is not under many duties and obligations besides these herein set forth. In a word, it is incumbent on the physician that under all conditions, his bearing toward patients, the public and fellow practitioners should be characterized by a gentlemanly deportment and that he constantly should behave toward others as he desires them to deal with him. Finally, these principles are primarily for the good of the public, and their enforcement should be conducted in such a manner as shall deserve and receive the endorsement of the community.

THE MARCH OF MEDICINE

Of the twelve radio stations which carry the State Medical Society programs, THE MARCH OF MEDICINE, eight have used broadcasts sponsored by the Society continuously for a year or longer. These are: WDSM, Superior; WIBA, Madison; WIGM, Medford; WJMC, Rice Lake; WKBH, La Crosse; WLBL, Stevens Point; WMAM, Marinette and WOMT, Manitowoc. Three stations, WATW, Ashland, WEAU, Eau Claire and WJMS, Ironwood, Michigan, started presenting these health programs in April of 1945 and the Green Bay station, WTAQ, first broadcast them in July, 1945.

Toward the end of the year guest speakers were included in the series among whom were Drs. William D. Stovall, Philip P. Cohen, C. N. Neupert, and Colonel William J. Bleckwenn. Dr. Harold M. Coon interviewed Colonel Leo P. Levenick, Director of the Wisconsin Department of Veterans Affairs on the subject, "Emergency Medical Care for Veterans."

Many requests for information have come to the Society as a result of the discussions in the radio series. Each letter is answered personally on behalf of the Committee on Health and Public Instruction. These replies give general information concerning the inquiry and refer the individual to his family physician for attention to his specific problem.

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YOUR DEAD LINES

Below are some of the "musts" of a practicing physician:

Taxes; Annual Narcotics Registration.

1. File your Wisconsin and federal income tax returns as early in 1946 as possible, *but not later than March 15.*
2. File a Social Security form quarterly just as in past years. Not later than January 31, 1946, you must file the return for the quarter ending December 31, 1945, and pay the employment tax due for that quarter.
3. The withholding tax, or tax withheld from the income of your subject employes, is due January 31 to cover the last quarter of 1945. It is due on April 30 for the first quarter of 1946, on July 31 for the second quarter, and on October 31 for the third quarter. On January 31 you must file a list of your employes and the amounts paid to them in salaries and the amounts withheld during 1945.
4. The first quarterly estimate of your own income for 1946 is due on March 15. Further estimates are due on June 15, September 15, and January 15. On those dates you may also amend your March estimate.
5. Register as required by the federal narcotics law, and pay the annual tax *before* July 1, 1946. You are subject to penalties for overlooking either the registration or the tax.

Annual Registration:

1. Register with the Secretary of the Wisconsin State Board of Medical Examiners in the month of January, 1946. This registration will be on a form furnished by the Board of Medical Examiners.

Change of Residence:

1. If you are registered under the Selective Service Act, notify your local draft board of changes of residence or temporary absences.
2. Notify the collector of internal revenue to insure the legality of your narcotics license. Penalties are imposed for failure to do this.
3. If you take up residence in another county, record your license with the county clerk so that no question will arise as in the collection of your fees.
4. If you have changed the address or place of residence or professional office or shall have opened an additional office after your annual registration in January, 1946, you must, within 30 days thereafter, notify the Board of Medical Examiners in writing of such change.

Remember to:

1. Make prompt report to the State Board of Health of cancer cases, communicable diseases and others as described in the article on page 92.
2. File with the city health officer or county register of deeds a certificate for all births attended by you within five days of the event. Otherwise your medical fees are unlawful. Sec. 69.30, statutes.
3. Register with the county judge if you desire reference work on commitment proceedings for persons allegedly insane, epileptic, inebriate, mentally deficient, and drug addicts. Registration is limited to physicians who have practiced for two years, or have had one year's experience in a hospital for the insane. Sec. 51.01 (2), statutes.
4. Notify the next of kin or a person who may be chargeable with the funeral expenses before you send, or cause to be sent, the corpse of any deceased person to a funeral director, undertaker, mortician or embalmer. The penalty is severe for failure to do so. Secs. 156.14; 156.15 (1), statutes.

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The constipation frequently encountered during pregnancy, due to pressure of the fetus on the pelvic bowel, lack of exercise, and restricted diet, is alleviated by Metamucil.

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SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

Milwaukee Rehabilitation Service Available to Veterans

IN LAST year's issue of the Blue Book attention was called to the establishment of a rehabilitation service available to veterans through the Milwaukee Neuropsychiatric Society. In determining the continued work of the rehabilitation work being carried on we have received the following report from Mr. Edward D. Schwade, director:

"In December, 1944, the service opened its doors to veterans suffering from neuropsychiatric disabilities of any origin, whether service connected or not. The underlying philosophy of the service has been aimed especially at diagnosis and intensive treatment and *the Service is not at all interested in the problem of claims against the government.* The Milwaukee Neuropsychiatric Society has felt that reports to organizations referring these cases should not be made in view of the fact that in most instances the reports are used rather for the establishment of claims than for active economic or social rehabilitation. It has been the further feeling of the Society that the ultimate goal of the Rehabilitation service shall aim only at psychiatric treatment and normal readjustment to civilian life and civilian pursuits.

"The response from doctors has been excellent and voluntary lay help has been secured through the Office of Civilian Defense and through friends who were interested in the project.

The set-up at the Clinic is as follows: The neuropsychiatric director of the Service, two receptionists, four secretarial workers, two psychologists, and one nurse constitute the staff. Social case work has thus far been handled through active contact with the referring agencies. A psychiatric social worker has not been available as yet, but it is the intention of the Service to obtain a full-time psychiatric social worker in the near future. Until the present time the Service has had well over 200 new patients and approximately 500 clinical visits. The average number of visits has been established as three. A recent survey indicated that with few exceptions the patients were completely satisfied with the services rendered. The Milwaukee Rehabilitation Service is still meeting once a week on Monday evening and is still being carried on at the Milwaukee Curative Workshop Building. The service is in session from 7:30 until 9:30 or 10:00 o'clock each Monday night, holidays excepted.

With the increased number of veterans it is anticipated that the Service will undoubtedly increase in scope and the Milwaukee Neuropsychiatric Society has made an appeal to the Milwaukee County Community Fund for help in expanding the clinical services and to help in placing the Clinic where it properly belongs as a recognized unit of medico-social service in the community."

Physicians interested in availing themselves of this service can secure further information by writing Mr. Schwade in care of the Milwaukee Rehabilitation Service, 750 North Eighteenth Street, Milwaukee 3, Wisconsin.

LOCATIONS AND OWNERS OF RESPIRATORS THROUGHOUT THE STATE

Appleton, St. Elizabeth's Hospital

Delavan, Volunteer Fire Department, Delavan Lake

Fond du Lac, St. Agnes Hospital

Green Bay, Bellin Memorial Hospital (Owned by Chicago and Northwestern Railway Company); St. Mary's Hospital; St. Vincent's Hospital

Juneau, County Highway Department Shop

Kenosha, Kenosha Isolation Hospital

La Crosse, Heileman Brewery Company; St. Francis Hospital

Madison, St. Mary's Hospital; State of Wisconsin General Hospital (2); Wisconsin Orthopedic Hospital for Children

Manitowoc, Holy Family Hospital (2)

Marinette, Marinette General Hospital

Milwaukee, Milwaukee County General Hospital (2) (Owned by Milwaukee County Chapter of the National Foundation); South View Isolation Hospital (3)

Neenah, Theda Clark Memorial Hospital

Oshkosh, Mercy Hospital; Winnebago County Court House

Port Washington, St. Alphonsus Hospital

Racine, Lincoln Isolation Hospital; St. Luke's Hospital

Sheboygan, Sheboygan County Court House

Superior, St. Mary's Hospital

Wausau, County Highway Department

West Bend, St. Joseph's Hospital

Wild Rose, Wild Rose Hospital

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Provisions of Wisconsin General Hospital Law

ACCORDING to the provisions of chapter 142 and section 36.31, Wis. Stats., the State of Wisconsin General Hospital, located in Madison, was established for two primary purposes: (1) to furnish facilities for teaching and the advancement of medical knowledge; and (2) to furnish specialized facilities for the care and hospitalization of patients lacking such facilities within their own communities.

142.01 **Public patients.** (1) A person having a legal settlement in any county in this state who is crippled or ailing and whose condition can probably be remedied or advantageously treated, if he or the person liable for his support is financially unable to provide proper treatment, may be treated at the Wisconsin general hospital or the Wisconsin orthopedic hospital for children at Madison or in such other hospital or rehabilitation camp as the county judge shall direct, except that when the person to be treated, or his guardian if he be under guardianship, shall select that such treatment be at the said Wisconsin general hospital or the said Wisconsin orthopedic hospital or rehabilitation camp, the hospital or rehabilitation camp of his selection shall be the place of treatment; provided that the right of such selection shall not exist in counties having a population of five hundred thousand or more . . .

142.02 **Application.** When the case of such person shall come to the notice of the sheriff, county supervisor, town clerk, health officer, health nurse, poor commissioner, policeman, physician or surgeon, or any public official, he shall and any teacher, priest or minister may, file with the county judge of the county wherein such afflicted person has a legal settlement an application for such treatment at such hospital.

The judge then appoints a physician to investigate the physical condition of the patient. At the same time the judge makes an investigation as to the propriety of such a commitment. The supervisor of the town, village or ward of residence of the person is required to furnish the court, upon request, with all material information within his knowledge in order that the judge may intelligently decide the case. If the judge is satisfied that the patient or the person liable for his support is financially unable to provide proper treatment and upon recommendation of the physician that the patient is a proper person for hospitalization at the State of Wisconsin General Hospital, the judge shall then issue an order approving such hospitalization, in which instance the cost is borne equally by state and county, provided that the county has not exceeded its quota for that year.

Unless the case is an emergency, the hospital desires the court order certifying the patient to the institution prior to the arrival of the patient. This allows the hospital to delay admission in certain cases where the services are already overcrowded.

Patients are also admitted to the hospital upon receipt of a letter from the family physician stating that the patient can pay $7 a day, in advance, for hospitalization, but that a professional fee or extras in addition would be a severe hardship. A few private cases are also admitted, but the hospital is not primarily interested in this type of work. Address all communications to the office of the Superintendent, 1300 University Avenue, Madison, Wisconsin.

Classification of patients admitted to the hospital is given below:

1. *County-state patient:* Hospitalization is authorized by the county judge of the county in which patient resides. Hospitalization costs are paid equally, half by the county and half by the state unless that county's quota for that year is exhausted in which case the county bears the full burden.

2. *Special rate patient* (formerly called the "clinic case"): This type of patient comes to the hospital on his physician's recommendation that he be accepted on a $7 per day basis. A financial statement of the patient is taken on admission, and if it is felt that his status justifies a $7 per day charge, he is admitted on that basis. He is thereby entitled to every service except transfusions and special nursing.

3. *Private patient:* This type of patient is handled the same as would be the case in any other hospital *except* that he is accepted only on reference or recommendation of the physician in the home community.

4. *War Veterans:* Any honorably discharged veteran of any war of the United States, who has been a resident of the state for not less than five years preceding his admission, may be admitted to the hospital and obtain all care including professional service at the established per diem rate ($5.90). War veterans are required to present their honorable discharge papers and sign a statement declaring residency for the last five years preceding admission to the hospital.

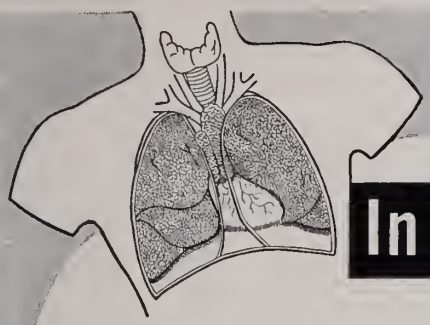
No patient is accepted at Wisconsin General Hospital unless referred or recommended by the patient's physician, except in case of emergency or accident where delay may cause serious complications.

Divisions of Wisconsin General Hospital

Wisconsin General Hospital: Admissions per above; general hospital service plus teaching privileges in connection with the University.

Wisconsin Orthopedic Hospital: Orthopedic and plastic surgery patients only. All patients admitted through the regular admitting channels of the Wisconsin General Hospital. Crippled Children's Division secures admission for many patients through its services.

(Continued on page 152)



In the Pneumonias

DURING the recent past, numerous investigations have shown that penicillin is the treatment of choice in the pneumonias (pneumococcic, streptococcic, staphylococcic).* Penicillin is virtually nontoxic, even in the massive dosages at times required. Its efficacy apparently is the same against sulfonamide-resistant and nonresistant organisms of the groups named. Even in advanced stages of the disease, in the presence of serious complications, penicillin usually proves a life-saving measure.

Since penicillin has become available in quantities that may well be adequate for all needs, it merits being the physician's first thought with every pneumonia patient.

*Stainsby, W. J.; Foss, H. L., and Drumheller, J. F.: Clinical Experiences with Penicillin, Pennsylvania M. J. 48:119 (Nov.) 1944.

McBryde, A.: Hemolytic Staphylococcus Pneumonia in Early Infancy; Response to Penicillin Therapy, Am. J. Dis. Child. 68:271 (Oct.) 1944.

Stainsby, W. J., Chairman, Commission for the Study of Pneumonia Control of the Medical Society of the State of Pennsylvania: Up-to-Date Facts on Pneumonia, Pennsylvania M. J. 48:266 (Dec.) 1944.

Larsen, N. P.: Observations with Penicillin, Hawaii M. J. 3:272 (July-Aug.) 1944.

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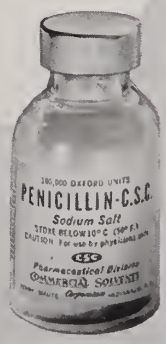

Bradley Memorial Hospital: This is a unit of Wisconsin General Hospital.

University of Wisconsin Infirmary: Student health center and hospital.

Wisconsin Psychiatric Institute: Furnishes facilities for blood and spinal fluid Wassermann examinations for the various state agencies and institutions, and for any physician desiring its facilities.

Scope and Fees

Provisions of the Wisconsin General Hospital Law as it relates to the relief of the medically indigent are contained in the "Summary of Wisconsin Poor Relief Laws Affecting Care of Indigent Sick," pages 95 and 96, January, 1944, issue, and the purpose of this article is to treat particularly the extent of the law and the collection of physicians' fees allowed thereunder.

Treatment May Be at Home or in Local Institution

Under the Wisconsin General Hospital Law (sections 142.01 and 142.04) a person having a legal settlement in any county, who is crippled or ailing and whose condition can probably be remedied or treated advantageously, and for whom treatment is financially impossible, may be confined, as the situation warrants, in the Wisconsin General Hospital, in the Wisconsin Orthopedic Hospital, in a local institution or at home.

Conditions Necessary to Local Treatment

Where treatment is to be given at home or in a local institution, the court must find that such treatment will be adequate and at the same or less expense to the county. But it must be kept in mind that the law is beneficent, and must be construed to give effect to its purpose. Thus the Attorney General has held that treatment need not be ordered at Madison in the emergency case, even though the expense might be less than in a local institution, because "it is not believed that the treatment at Madison would be considered adequate. . . ." (XXII Atty. Gen. 465). And in the consideration of "expense," the county judge may take into account the costs necessary to remove a patient to Madison, for transportation expense, and those of an attendant, both to and from the institution, are not items of joint state and county expense.

The County Quota

Under the provisions of the law, state aid ceases when the total county patients committed from any one county exceeds a ratio of more than two persons per thousand of population or major fraction thereof, although there is no limit if there is no hospital in the county concerned nor as to patients certified to the Wisconsin Orthopedic Hospital. The decision whether there is a hospital in the county is for the secretary of state at the time he certifies to the county its share of the costs. 30 Atty. Gen. 98. If the county exceeds its quota, then the county must pay the entire cost of hospitalization if the patient is to be confined in Madison. If the patient is confined at home under the provisions of the law, no expense of hospitalization is involved at all. The only expense to the county would be that of medical care and nursing.

Physicians' Fees

In proceedings under the Wisconsin General Hospital Law, two entirely separate and distinct fees are permitted physicians.

By provisions of section 142.03 (2) the county judge, if satisfied that a patient presents a proper situation, "shall appoint a physician personally to examine the person." By statute, the physician is directed to make a verified report in writing giving certain required information, and shall "be paid by the county $5.00 and actual and necessary expenses." Since no method is provided for the payment of the physician, he must proceed through legal channels for the collection of the $5.00 fee allowed. Following the provisions of section 59.77 (1), dealing with claims against the county, the physician must make a statement of his claim in writing upon county voucher forms setting forth its nature and the facts upon which it is founded. If the claim includes mileage, the statement should specify the days and places, so as to show between what points, and when, and the purpose for which the travel charges were made. Since the fee is statutory, the time expended in the performance of service need not be stated. But the statement must be verified by affidavit and filed with the county clerk, whose duty it is, under the provisions of section 59.79 to transmit the same to the county board.

The expense of treatment of such patients, in local institutions or at home, shall be paid by the county treasurer, upon the certificate of the county judge who shall be satisfied as to the correctness and reasonableness thereof. The claim of the physician rendering the treatment need not be passed upon by the county board, but only by the county judge. See sections 142.04 and 142.08 (5). See also 21 Atty. Gen. 240 and 22 Atty. Gen. 408.

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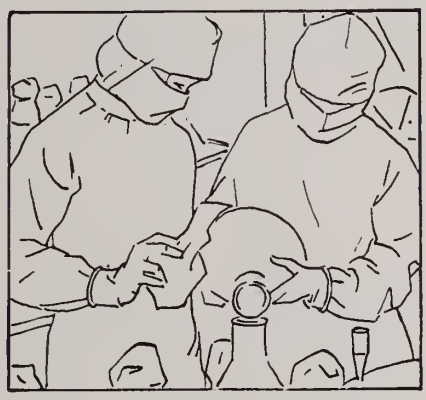

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A. L. Castleman, Delafield 1850, 1851
Harmon Van Dusen, Mineral Point 1852, 1853, 1854
A. L. Castleman, Delafield 1855
John Mitchell, Janesville 1856
D. Cooper Ayres, Green Bay 1857
Clark G. Pease, Janesville 1858, 1859
E. S. Carr, Madison 1860, 1861
Solomon Blood, Rochester 1862
(No meetings held from 1863 through 1866; apparently no new officers).
Harmon Van Dusen, Mineral Point 1867, 1868, 1869
Solon Marks, Milwaukee 1870
H. P. Strong, Beloit 1871
John Favil, Madison 1872
Harmon Van Dusen, Mineral Point 1873
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W. E. Ground, Superior 1908
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Edward Evans, La Crosse 1910
Byron M. Caples, Waukesha 1911
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Stephen E. Gavin, Fond du Lac 1937
James C. Sargent, Milwaukee 1938
A. E. Rector, Appleton 1939
R. G. Arveson, Frederic 1940
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Gunnar Gundersen, La Crosse 1942
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Dr. John J. McGovern†	1931
Dr. Louis M. Jermain†	1931
Dr. Edward Evans†	1931
Dr. Mina B. Glasier	1932
Dr. Arthur W. Rogers†	1934
Dr. Rock Sleyster†	1934
Dr. Olin West*	1934
Edward A. Birge, Ph. D.**	1935
Dr. Arthur J. Patek	1935
Dr. Joseph F. Smith	1937
Dr. Eben J. Carey	1938
Dr. William S. Middleton	1938
Dr. Fred G. Johnson	1939
Dr. William D. Stovall	1940
Dr. Ludvig Hektoen***	1941
Dr. Stephen E. Gavin	1944

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** Then president of the University of Wisconsin and professor of zoology.
*** Centennial Award.
† Deceased.

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THE JOURNAL BOOKSHELF

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, S. M. I. Building, Madison, Wis.

A Text-Book of Neuro-Anatomy. By Albert Kuntz, Ph.D., M. D., Professor of Micro-Anatomy in St. Louis University School of Medicine, St. Louis, Missouri. Cloth. Price $6.50. Pp. 478 with 325 engravings. Philadelphia: Lea and Febiger, 1945.

The author presents in this volume a comprehensive account of the anatomy of the central nervous system. Of necessity he has included sufficient physiologic data for an understanding of function. The subject matter is set forth in an orderly manner and without too great detail.

Beginning with the evolution and comparative anatomy of the nervous system, the student rapidly gains a conception of the development, external, and internal anatomy of the brain and spinal cord. The study of the reflex arcs and long conduction paths is held in abeyance until the student is familiar with this anatomic background. In so far as possible, the author has avoided confusing detail and held fast to fundamental concepts so that the beginning student is not confused by unrelated detail. The chapter on the automatic nervous system contains all of the essential knowledge of visceral function and is presented in a lucid manner.

There has been no effort on the part of the author to make this a reference book. It is rather an excellent primer of neuro-anatomy and contains all the essential accurate knowledge of the anatomy and physiology of the brain and spinal cord necessary to a beginning student. J. H. R.

The Medical Clinics of North America. Chicago number. Symposium on Neuropsychiatric Diseases. 23 contributors. Cloth. Pp. 271 with illustrations (photographs), drawings, charts, and tables. Philadelphia: W. B. Saunders Company, 1945.

This volume consists of a series of 15 articles on neurological, neurosurgical, and psychiatric subjects, to which have been appended three further communications of more purely medical interest. Of especial interest to the general practitioner are those articles on The Diagnosis and Treatment of Peripheral Nerve Injuries (Loyal Davis), Relief of Facial Pain (A. E. Walher), Management of Masthenia Gravis (R. Richter), and Insomnia (M. Solomon). These are concisely presented and provide broad and practical viewpoints of the respective fields. However, much of the remaining material is of a too specialized and often controversial nature, and in some cases will not provide the non-specialist reader with a definitive or even generally accepted presentation of the subject matter. J. S. L. J.

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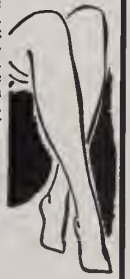

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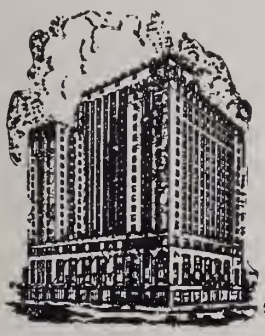

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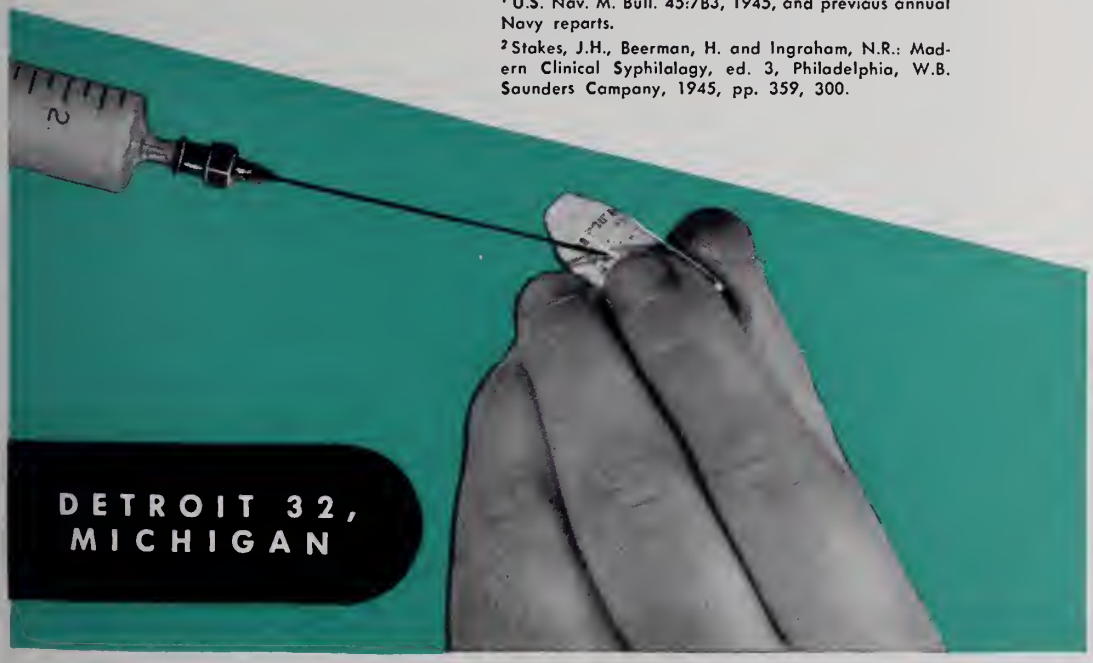
[2] Stokes, J.H., Beerman, H. and Ingraham, N.R.: Modern Clinical Syphilalagy, ed. 3, Philadelphia, W.B. Saunders Campany, 1945, pp. 359, 300.



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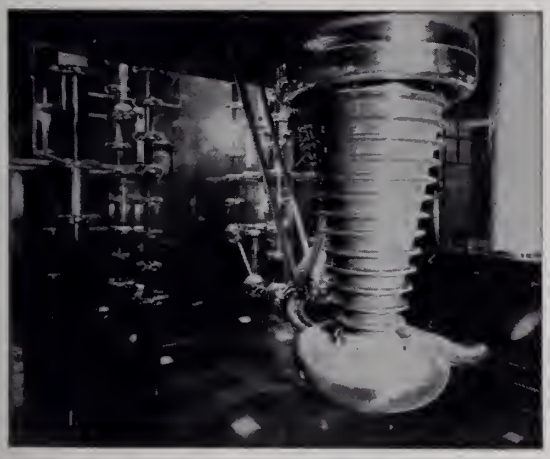

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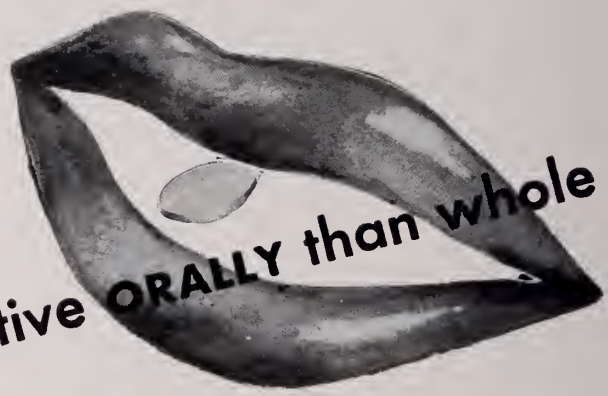

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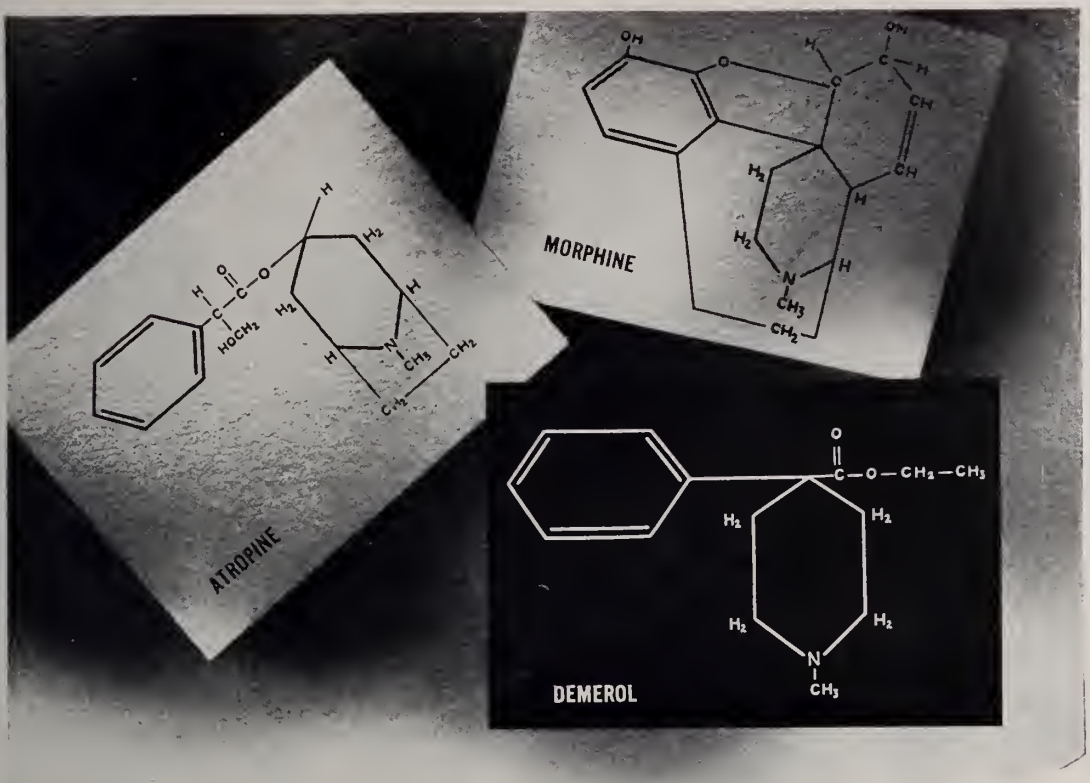

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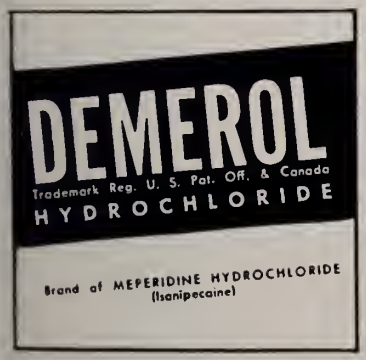

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*Frazer, J. G.: The Golden Bough, vol. 1, New York, Macmillan & Co., 1923

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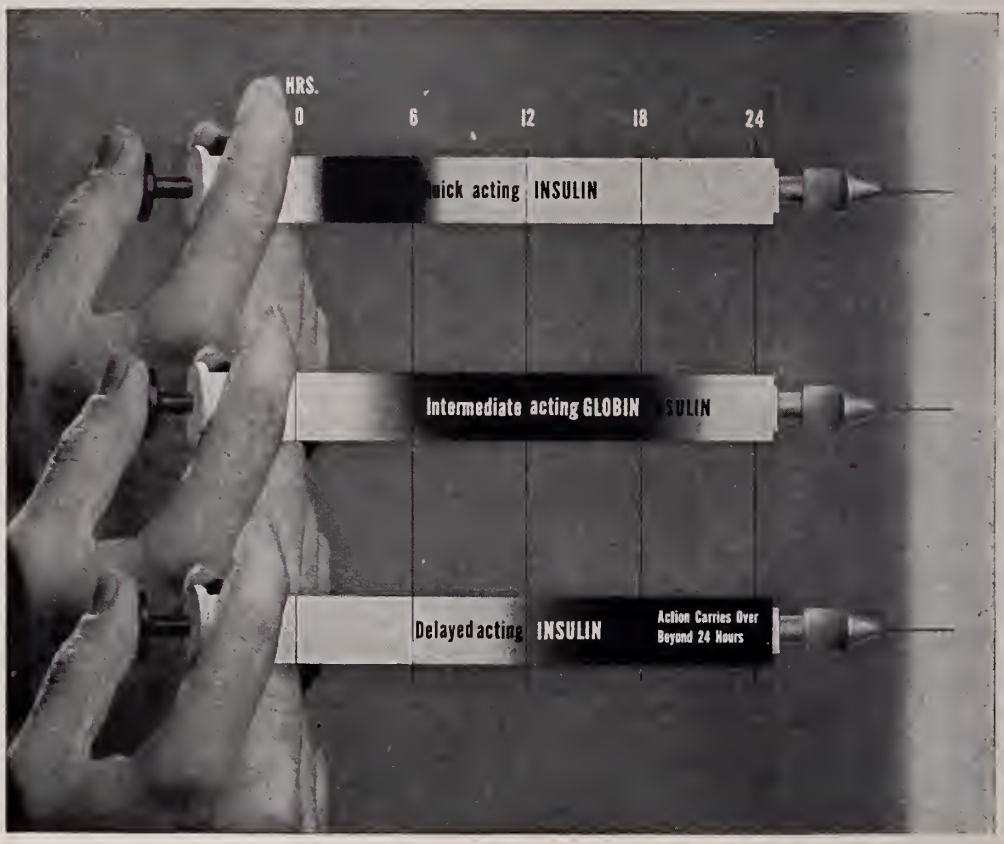

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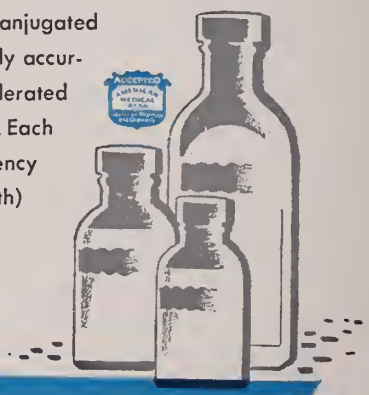

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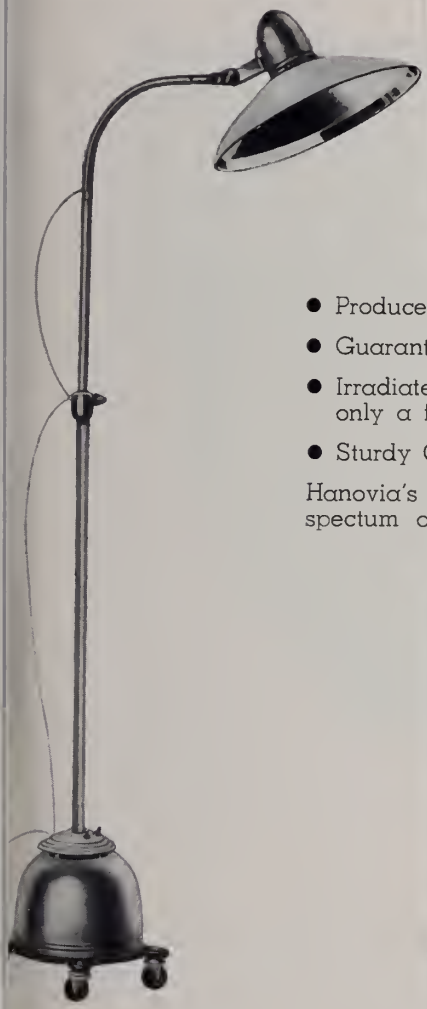

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*Keefer C. S. et al.: New Dosage Forms of Penicillin, J.A.M.A. 128: 1161 (Aug. 18) 1945.

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THE WISCONSIN MEDICAL JOURNAL

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Seven-Year Report From Neuropsychiatric Department, Student Health Service, University of Wisconsin

By ANNETTE C. WASHBURNE, M. D.
Madison

ANNETTE C. WASHBURNE

Dr. Washburne is associate professor of neuropsychiatry at the University of Wisconsin Medical School, and is director of neuropsychiatric service in the Department of Student Health at the university. A fellow of the American College of Physicians, she is a member of the American Psychiatric Association, the Central Neuropsychiatric Association, the Milwaukee Neuropsychiatric Association and a diplomate of the American Board of Neurology and Psychiatry.

IN 1937 the Regents of the University of Wisconsin established a Neuropsychiatric Department in the Student Health Service of the university. The need for such a department had been foreseen for several years by a number of university faculty members who had become increasingly aware of psychologic problems among students. The department was opened in September, 1937, with a staff consisting of one full-time neuropsychiatrist, one half-time neuropsychiatrist, and one full-time stenographer. From September, 1937, to September, 1944, a total of 4,605 student patients have been interviewed, examined, and treated in the department.

At the present time it seems that a report summarizing the types of cases, together with a resumé of our general methods of procedure, might be of interest to the medical profession of Wisconsin, many of whom have kindly referred students to us.

General Summary of Cases

The 4,605 student patients represented a total of 14,103 conferences and/or examinations. Of these, 3,935 were "new" patients, that is patients who were interviewed and treated for only one semester; 670 student patients were "carry-overs," that is patients interviewed and treated for two or more semesters.

I. General Diagnostic Classification

	Total	New Patients	"Carry-Overs"
Psychiatric cases	2,231	1,650	581
Psychiatric examinations for:			
A. The teachers' certificate	919	919	
B. The School of Nursing	225	225	
Rorschach testing	303	303	
Neurologic cases	414	325	89
Medical cases	127	127	
Miscellaneous (Students seeking advice regarding others, but not themselves presenting psychiatric problems)	262	262	
Undetermined diagnoses	124	124	
	4,605	3,935	670

II. Detailed Diagnostic Classification and Discussion

Psychiatric cases. The 2,231 psychiatric cases were grouped under the following eight headings:

A. Psychoses	Total	New Patients	"Carry-Overs"
Dementia praecox	30	24	6
Manic depressive psychosis	23	19	4
Involutional psychosis	10	7	3
Paranoia	2	2	
Paranoid psychosis	1	1	
Toxic psychosis	1	1	
	67	54	13

With psychotic patients our procedure has been to recommend a period of observation in the Student Infirmary sufficient to estab-

lish a diagnosis. In a few of the extremely disturbed cases it was necessary to transfer the patients to the Neuropsychiatric Department of the Wisconsin General Hospital for this study. In all instances "observation" included, in addition to psychiatric studies, physical and neurologic examinations and necessary laboratory procedures.

Shock therapy was given to six patients with dementia praecox and to one patient with a paranoid involutional psychosis. In this group, one patient received insulin, one insulin and metrazol, and the other five patients were given electric shock therapy. Three cases of early dementia praecox, who had received electric shock treatment, recovered sufficiently to return to school and complete their university work; two of them showed fair improvement, but were advised against further scholastic effort; one advanced praecox underwent rapid deterioration. No improvement was obtained in the case of the involutional psychosis.

With one exception, the other psychotic cases, who did not receive shock therapy from us, were institutionalized elsewhere with the cooperation of their families. The one exception was a student who developed a toxic psychosis in the course of lobar pneumonia and was cared for in the Infirmary.

When, in our opinion, there was sufficient evidence to warrant the diagnosis of a psychotic condition, the family was notified, asked to come in to discuss the case, and to signify their wishes or consent for therapy.

B. Incipient psychoses: 182 patients were examined who were in a sufficiently serious condition to warrant our considering them "borderline psychotics." In no case was there evidence of actual psychotic behavior in the generally accepted use of that term.

	Total	New Patients	"Carry-Overs"
Incipient dementia praecox	80	40	40
Incipient manic depressive states	39	24	15
Paranoid states without psychosis	7	6	1
Depression states	42	32	10
Panic states	14	11	3
	182	113	69

The boundary line between psychotic and neurotic behavior is often difficult to evaluate. As we have previously remarked, "The determination of a possible merging period between," (for example) "a regression neurosis and a schizophrenia is similar to a study in delicately shifting pastels, with the answer in each case largely dependent upon the intuition, idiosyncrasies and clinical experience of the observer."[1] From *one point of view* it may make little difference what diagnostic label is attached to a given psychiatric case, but from *the practical angle* of deciding what course to pursue, how much protection to provide for the patient and what advice to give the university and the student's family, careful diagnostic evaluations appear essential to us. In such evaluations it has been our policy to take into serious consideration regressive schizoid patterns, cyclic nonpsychotic mood shifts, paranoid constellations, depressions, and episodes of panic. While many of these could be viewed as evidence of neurotic behavior, we have preferred to think of them as incipient *psychoses*, believing that by so doing we will increase our own watchfulness.

When, therefore, psychiatric studies reveal such symptoms in a *quantitatively* significant amount, a more intensive study is undertaken, including, in most cases, a period of infirmary observation. Such hospitalization is insisted upon in depression and panic states. During this time daily conferences are maintained, and medication is employed as indicated. It has been our feeling that these precautionary measures have been largely responsible for the fact that within the seven-year period this department has operated there have been no suicides among patients who have been under our care.

C. Psychoneuroses (exclusive of psychasthenia and hysteria)

	Total	New Patients	"Carry-Overs"
Tension anxiety neuroses	865	666	199
Fatigue neuroses (neurasthenia	91	71	20
Adolescent reactions exhibiting neurotic behavior	125	106	19
	1,081	843	238

Of the various psychiatric reactions seen by us, the *tension anxiety neuroses* were by far the most common. The principal symptoms included a *psychologic* over-reaction consisting of apprehension, anxiety, abnormal worry, and fear. The *somatic* components included headache, muscular tension, gastro-intestinal and cardiac complaints.

(Where such symptoms persisted or where a reasonable doubt as to possible organic pathology existed, pertinent neurologic, physical, and roentgenologic examinations were carried out.) The majority of the tension anxiety neuroses presented a situational etiology, usually in the nature of sexual conflicts or home difficulties. The majority were benign in nature, yielding to therapy within a period of several weeks to months.

The *fatigue neuroses* were studied in some detail. All of these patients were given physical and neurologic examinations. In addition, a number of laboratory studies were carried out; these included basal metabolic rates, sugar tolerance, calcium and phosphorus determinations, alkali reserve, blood serum chloride, serum cholesterol, complete blood counts and urine analysis, and, in a limited group, gravity shock tests. (The gravity shock tests were given with the assistance of Drs. Marie L. Carns and Edgar Gordon of the Department of Internal Medicine and Dr. Frances Hellebrandt of the Department of Physiology. At a later date the results of this study will be published in detail.)

In general, patients with fatigue neurosis presented many of the signs and symptoms associated with neurocirculatory asthenia. The majority exhibited an asthenic habitus, cold "clammy" skin, often with subcyanosis of the hands and feet, systolic blood pressure below 110, normal basal metabolic rates, and low sugar tolerance curves. It was of interest that the group taking the gravity shock tests showed somewhat greater resistance than a group of normal controls. Psychologically, these patients presented a long standing history of easy fatigability, lack of accomplishment drive, and a listless apathetic manner. All of them had experienced psychologic conflicts of considerable severity; the majority of these were concerned with sexual maladjustments and work, that is school, problems.

Adolescent reactions exhibiting neurotic behavior were seen most frequently among the younger students. The majority of these were freshmen whose history indicated that they were "only children," away from home for the first time from overly aggressive or protective parents. In nearly all instances there was clinical evidence of emotional immaturity, impulsive behavior, exaggerated ideas of "life and world problems," and in general, a point of view influenced by prolonged adolescence and (often) acne vulgaris. In some of these cases it was deemed advisable to recommend withdrawal from the university for a semester or a longer period of time. During this interval the student and family were urged to investigate job possibilities more in keeping with the emotional status of the patient.

D. Psychasthenia	Total	New Patients	"Carry-Overs"
Kleptomania	11	8	3
Compulsive states	28	21	7
Phobias	19	13	6
Pathologic liar	1	1	
	59	43	16
E. Hysteria			
Conversion hysteria	78	50	28
Anxiety hysteria	43	29	14
	121	79	42

The *psychasthenics* were a numerically small group. This was fortunate considering the large expenditure of time required in this type of case.

The *conversion hysterias* showed a preponderance of "glove and stocking" anesthesias, "paralysis" of an extremity, and globus phenomena. Good results for the immediate difficulty were obtained in nearly all cases by the use of suggestive therapy or narcoanalysis (intravenous sodium amytal).

F. Psychopathic personalities	Total	New Patients	"Carry-Overs"
	620	437	183

Six hundred twenty patients were seen whose personalities, evaluated on a *quantitative* basis, were considered to be inadequate. This inadequacy was noted in their repeated failure to cope with various life situations, whether at home or in the university. While a number presented neurotic symptoms including antisocial tendencies, irritability, and impulsive behavior, their primary difficulty was considered essentially constitutional and their neurotic episodes viewed as episodic "flareups" superimposed on their fundamental maladjustment. The history in most cases indicated hereditary tainting, unfavorable early evironment, and faulty training. With this group our main efforts were dir-

ected toward treatment of the neurotic episodes, since it was clear that little or nothing could be done to change their basic psychopathic patterns.

G. Mental dullness	Total	New Patients	"Carry-Overs"
	16	16	

Sixteen patients were interviewed whose intelligence quotient was below that considered adequate for university work. All of this group were referred because of difficulty with scholastic work. The majority had completed high school training in small schools, some of which required few if any written examinations. All 16 were "new patients" and for obvious reasons none were carried over.

H. Miscellaneous	Total	New Patients	"Carry-Overs"
Menopausal syndrome	16	11	5
Migraine	54	42	12
Speech defects	6	4	2
Malingerers	2	2	
Students referred by the police for psychiatric evaluation to explain behavior difficulties which had led to their arrest	7	6	1
	85	65	20

The *menopausal syndrome* was observed most frequently in the summer sessions among older students in the graduate school. All cases were referred for gynecologic examination to our gynecologic consultant, Dr. M. J. Thornton. Where indicated, substitution treatment was combined with psychotherapy.

Patients presenting *migraine* were given neurologic examinations and in most cases x-rays of the skull and sinuses were obtained. The greatest relief was obtained by reduction of scholastic schedules and the use of ergotamine tartrate. In this group, 10 patients presented the symptoms of ophthalmic migraine, namely, flashing scotomata without significant headache. Improvement was obtained in all but one case by the use of "micapon" (potassium chloride and calcium lactate) together with small doses of either phenobarbital or mebaral.

Five cases of *speech defect*, considered to be the result of psychologic conflicts, were studied. Fair success was obtained in only 1 patient.

The two *malingerers* were motivated in their simulation of pathology by a desire to escape examinations for which they were unprepared.

Six cases were referred by the *court or police* for psychiatric study. The police charges included stabbing another student with a knife, indecent exposure, sexual molesting of children, and window peeping. All cases showed evidence of emotional immaturity.

Psychiatric examinations were given to 919 students in the *School of Education*. These students were candidates for the teacher's certificate. The examinations covered a two-year period (September, 1937, to June, 1939) and were carried out with a view toward determining their usefulness and practicality. As the minimum time for each interview was thirty minutes, it became apparent that with our small personnel, these evaluations could be accomplished only at the expense of other students, who presented actual problems. Out of the total 919, it was recommended in only three instances that the teacher's certificate be withheld for psychiatric reasons. One case was a manic depressive psychosis (in hypomania at the time of examination) and the other two were cases of dementia praecox. It was felt, however, that even without the examination these 3 students would probably have been referred to us sooner or later by their advisors or instructors.

Since 1937, this department has, each year, conducted similar psychiatric evaluations, combined with psychologic testing, on all candidates for the *School of Nursing*. In so much as this is a smaller group than the candidates for the teacher's certificate, this routine examination has proved feasible both from the point of view of time expenditure and follow-up. Since the student nurses are in residence and work in the hospital, it has been a simple procedure to maintain contact with them throughout the period of their training. It has been a matter of interest to note in how many instances the psychiatric evaluation corresponded with scholastic grades and ward work. It has been the policy of the Student Health Department to exert particular care in the selection of physically

and psychologically healthy young women for the nursing school. This selection has been greatly aided by the excellent preliminary interview and counselling given each candidate by Miss Christina Murray, Director of the School of Nursing.

As psychiatric interviews with incoming university students had proved too time-consuming to be of practical value, an attempt was made in June, 1943, to evaluate the effect of a psychologic test for general screening purposes. Three hundred three students, admitted to the fifteen weeks summer session, were given the M. Harrower-Erickson "multiple choice" adaptation of the Rorschach test. The test was carried out by projecting the ten "ink blot" figures on a screen. The number of students taking the test at one time was limited to 20. As the results of this experiment have already been published,[2] only a few comments will be made here. Thirteen students gave seven or more "poor" (that is abnormal) answers on the first testing. This group, on being called in for recheck, showed essentially the same responses. Later clinical studies on these patients resulted in the following impressions:

Incipient schizophrenia	1
Anxiety tension neurosis	3
Adolescent reaction	2
Compulsive obsessive neurosis (psychasthenia)	1
Menopausal syndrome with neurotic patterns	1
Psychopathic personality	3
Impression deferred	2

Eight students who had also demonstrated seven or more "poor" answers on the first testing were found on recheck to be within the "normal answer" group. Two of these stated that they had not understood the first test; three had serious physical disabilities which colored their interpretations; one had a refractive error which made visualization of the screen difficult; one was suspicious and antagonistic toward the test; and one was undergoing a severe menstrual period. The clinical impressions in this group were:

Normal	6
Adolescent reaction	1
Psychopathic personality (the suspicious antagonistic student)	1

Eight students giving five or more "poor" answers, both on the first test and on repetition, exhibited clinically:

Incipient dementia praecox	1
Anxiety tension neurosis	2
Adolescent reaction	2
Mental dullness	1
Normal	1
Impression deferred	1

Thirty-six students giving five or more "poor" answers on the first test, but on repetition showing normal responses, were clinical evaluated as:

Normal	22
Anxiety tension neurosis	12
Fatigue neurosis	1
Psychopathic personality	1

From the total group of 303, 18 were given psychotherapy. It was felt that there was little probability that these students would have requested psychiatric help themselves. As a result of the procedure, it was our feeling that some such screening method, together with other psychologic tests, given in the freshman year, would prove of material aid in obtaining earlier and hence more effective therapy.

General Comments on the Psychiatric Cases

The psychiatric cases occurred more frequently in the freshman and graduate years. The first is understandable because of the necessary adjustments to a large university. The latter is perhaps explained by the statements made by many of our graduate school patients, namely, that they had elected to go on in graduate work, or had given up positions to resume graduate work, in the hope that this might solve their psychologic problems.

When the psychiatric problem was the result of situational maladjustments, it was found that sexual conflicts and home difficulties predominated over maladjustments arising from school work, social contacts, war worries, or racial, health, and religious issues.

Forty-seven per cent of the psychiatric cases occurred among men and 53 per cent among women.

The neurologic cases were grouped under the following six headings:

A. Cerebral pathology

	Total	New Patients	"Carry-Overs"
Skull fractures	5	5	
Cerebral concussion without fracture	77	75	2

	Total	New Patients	"Carry-Overs"
Gun shot wound of brain	1	1	
Subarachnoid hemorrhage	5	3	2
Cerebral thrombosis	2	1	1
Cerebral arachnoiditis	18	14	4
Brain tumor	2	2	
Foster Kennedy syndrome	1	1	
Brain abcess	2	1	1
Epilepsy	69	44	25
Cerebral hemiatrophy	1	1	
Christian Schilder disease	1	1	
Familial cerebellar disease	1	1	
Double athetosis	1	1	
Little's disease	6	5	1
Sydenham's chorea	2	2	
Acute encephalitis	5	3	2
Acute postvaccinal encephalitis	1	1	
Chronic encephalitis	21	14	7
Thalamic syndrome	1	1	
Hypothalamic dysfunction	4	2	2
Catalepsy (undetermined origin)	1	1	
Narcolepsy (undetermined origin)	7	6	1
	234	186	48

B. Vertebral and spinal cord pathology

	Total	New Patients	"Carry-Overs"
Vertebral fractures	4	4	
Platybasia	2	1	1
Spina bifida occulta	1	1	
Spinal cord tumor	1	1	
Transverse myelitis	1	1	
Herniated nucleus pulposus	15	10	5
Acute poliomyelitis	3	2	1
Residuals of former poliomyelitis	6	6	
Syringomyelia	10	5	5
	43	31	12

C. Central nervous system pathology involving brain and cord

	Total	New Patients	"Carry-Overs"
Meningococcic meningitis	10	6	4
Pneumococcic meningitis	2	1	1
Tuberculous meningitis (*)	1	1	
Choriomeningitis	9	5	4
Multiple sclerosis	12	8	4
Combined sclerosis	2	1	1
Central nervous system syphilis	6	4	2
	42	26	16

D. Pathology involving the muscular system

	Total	New Patients	"Carry-Overs"
Traumatic muscle injuries	9	9	
Muscular atrophy following anti-tetanus serum	1	1	
Aran-Duchenne's muscular atrophy	2	1	1
Progessive muscular dystrophy	1	1	
Scalenus anticus syndrome	3	2	1
Serratus magnus palsy	4	4	
	20	18	2

(*) Died.

E. Pathology involving cranial and peripheral nerves

	Total	New Patients	"Carry-Overs"
Retrobulbar neuritis	3	2	1
Trigeminal neuralgia	11	8	3
Bell's palsy	3	2	1
Meniere's syndrome	1	1	
Supra-orbital neuralgia	4	4	
Occipital neuralgia	2	2	
Ulnar nerve palsy	5	5	
Radial nerve palsy	3	2	1
Sciatica	4	4	
Herpes Zoster	2	2	
Neuronitis	3	2	1
Arsenical polyneuritis	1	1	
Traumatic peripheral nerve injuries	4	3	1
Peripheral neuritis without trauma	15	14	1
	61	52	9
F. Labyrinthitis	14	12	2

General Comments on the Neurologic Cases

Because of the wide variety of neurologic disorders only a few entities will be selected for brief comment.

Head trauma. All head trauma cases were seen promptly. Shock, if present, was treated first. Thereafter, careful neurologic and physical examinations were performed. Lumbar puncture and examination of the fluid for blood was performed in those cases in which such a procedure appeared advisable. Skull films were obtained in all cases. Consultation with a neurosurgeon (Dr. Theodore Erickson) was obtained whenever it appeared that surgical treatment might be a consideration.

Epilepsy. All students known to have epilepsy were asked to report to the Neuropsychiatric Department. Complete histories were elicited with a view toward obtaining: (a) possible etiology, (b) type of seizure, and (c) residual pathology in the nature of present physical or psychologic handicaps. Neurologic examinations and pertinent laboratory studies (including x-rays of skull) were obtained in all cases. Those students who gave a history suggesting an allergic etiology were referred to an allergist (Dr. William Mowry). A few cases which were considered to have a possible neoplastic basis were referred for electro-encephalographic or encephalographic studies. Cases of nocturnal epilepsy were given sugar tolerance tests and additional information was sought concerning their dietary habits. In general, epileptics were placed on dilantin with the

occasional addition of phenobarbital. All epileptics were given a "D" health grade which automatically carries with it an excuse from physical education and military science training. All were requested to report: (a) at monthly intervals for "check up," or (b) whenever they had had a seizure.

Herniated nucleus pulposus. Cases of intermittent or continuous back pain, especially with radiation down one leg, were examined neurologically and referred for x-ray studies of the involved region. If a trial rest in bed with traction on the leg failed to give relief, lumbar puncture for pressure studies and examination of the cerebrospinal fluid, particularly for protein, was performed. In a few doubtful cases, an air myelogram was performed. Surgery was carried out in 5 cases.

Meningitis. Six cases of meningococcic meningitis were treated with sulfadiazine with uniformly good results.[3] Two cases of pneumococcic meningitis were treated with various sulfonamides and both recovered; in one case a middle ear focus required additional surgical treatment. One case of tuberculous meningitis died. At autopsy miliary tuberculosis was found to be present. (This case, constituting our only mortality, occurred in a sailor, who was enrolled in the Radio School at the University.)

Platybasia was demonstrated by x-ray to be present in one case. This patient was referred to Dr. Theodore Erickson for surgery with satisfactory clinical results.

Of the total neurologic cases, 61 per cent occurred among men and 39 per cent among women. The medical cases were grouped under the following nine headings:

A. Burns and injuries

	Total	New Patients	"Carry-Overs"
Contusion of face	6	6	
Contusion of shoulder	1	1	
Laceration of hand	1	1	
Chemical burn of arm	1	1	
	9	9	

B. Pathology involving the eye, ear, nose, and throat

	Total	New Patients	"Carry-Overs"
Refractive error	4	4	
Sinusitis	14	14	
Occlusion of the Eustachian canal	2	2	
Abscessed teeth	2	2	
Tonsillitis	2	2	
	24	24	

C. Upper respiratory infections and pathology involving the chest and lungs

	Total	New Patients	"Carry-Overs"
La grippe	4	4	
Bronchial asthma	1	1	
Active pulmonary tuberculosis (*)	2	2	
	7	7	

D. Pathology involving the cardiovascular system

	Total	New Patients	"Carry-Overs"
Stokes-Adams syndrome	1	1	
Paroxysmal tachycardia	1	1	
Heart block (*)	2	2	
Hypertension	3	3	
Thrombosis of the inferior vena cava[1] (*)	1	1	
	8	8	

E. Pathology involving the gastro-intestinal system

	Total	New Patients	"Carry-Overs"
Gastro-enteritis	2	2	
Spasticity of the colon	3	3	
Ulcerative colitis (*)	2	2	
Acute appendicitis	1	1	
Chronic appendicitis (*)	2	2	
Taenia saginata	1	1	
	11	11	

F. Pathology involving the genito-urinary system

	Total	New Patients	"Carry-Overs"
Chronic glomerulo-nephritis (*)	1	1	
Hypernephroma (*)	1	1	
	2	2	

G. Endocrine dysfunction

	Total	New Patients	"Carry-Overs"
Polyglandular dysfunction	10	10	
Alopecia areata (*)	1	1	
Hypothyroidism	8	8	
Mastitis	1	1	
Diabetes mellitus (*)	1	1	
Hypoglycemia	6	6	
Achondroplastic dwarf (*)	1	1	
	28	28	

	Total	New Patients	"Carry-Overs"
H. Allergic disorders	12	12	

I. General and miscellaneous

	Total	New Patients	"Carry-Overs"
Infectious mononucleosis	1	1	
Acute rheumatic fever (*)	2	2	
Bursitis	4	4	
Tenosynovitis	1	1	
Arthritis (cervical spine)	2	2	
Ovarian cyst	1	1	
Pes planus	2	2	
Ganglion (foot)	1	1	
Splenomegaly (etiology undetermined)	1	1	
Sacro-iliac strain	4	4	
Bilateral cervical ribs	1	1	
Chronic iodine poisoning	1	1	
Vitamin deficiency	4	4	
Acute alcoholism	1	1	
	26	26	

* Diagnosis previously made.

General Comments on the Medical Cases

One hundred twenty-seven patients were referred to us for various reasons. In most instances, the medical diagnosis had previously been made in the Student Health Clinic, but it was felt there might be complicating neurologic or psychiatric factors. In some cases the original complaints had led to the impression that the responsible etiology was neurologic or psychiatric. In a few instances the patient came to us directly under the misapprehension that this department cared for all types of cases. No significient neurologic or psychiatric factors were found in any of this group.

Miscellaneous Group

Two hundred sixty-two students consulted us for advice or information concerning their friends or families. None of this group were found to have psychiatric or neurologic problems.

Undetermined Diagnosis

In 124 cases no diagnosis was made. In over 60 per cent this was due to failure of the student to return for further conferences or examinations.

III. General Aims of the Department

The general aims of the department include: (a) early diagnosis, (b) active treatment, of sufficient duration, in all cases in which it is felt that such treatment is indicated, (c) advice to withdraw from the university to those students found to be: (1) psychotic, or (2) too grossly maladjusted for therapeutic help (especially where such maladjustments interfere with the welfare of others).

From September, 1937, to September, 1944, advice to withdraw from the university for one of the above reasons was given to 231 students, 57 of whom were psychotic. Of the 231, 52 upon subsequent examinations were found sufficiently improved to warrant readmission. When a student withdraws for reasons of neuro-psychiatric health, he is requested to report to this department for re-examination before recommendations are made for continuation of university work.

* Diagnosis previously made.

IV. General Results Obtained

It is obviously difficult to evaluate the amount of improvement in many neuropsychiatric cases. The following criteria for estimating clinical progress have been adopted with, however, a realization of their limitations.

A. Development of insight.

B. Ability of the patient to:

1. Solve
2. Meet or accept his problem
3. Alter his viewpoint toward it

C. The patient's own statements concerning his improvement or lack of improvement.

D. Progress in school and in social adaptation.

E. Improvement as noted or not noted following:

1. Surgery (as in cases of herniated nucleus pulposus, brain tumor, etc.)
2. Shock therapy (as in cases of psychoses)
3. Medical treatment (as in cases of epilepsy)

F. Evaluation of the whole case at the conclusion of treatment by the neuropsychiatrist.

Based on the above criteria, the 2,645 *combined* psychiatric and neurologic cases were evaluated as follows:

Improved	50%
Not improved	26%
Insufficient data to warrant conclusions	24%

The 2,231 psychiatric cases were evaluated as:

Improved	48%
Not improved	27%
Insufficient data to warrant conclusions	25%

The 414 neurologic cases were evaluated as:

Improved	59%
Not improved	21%
Insufficient data to warrant conclusions	20%

V. Special Considerations

In treating the neurologic and psychiatric problems of students individually and *directly*, the Neuropsychiatric Department of Student Health attempts to contribute *indirectly* to the general personnel program and

to the welfare of the university as a whole. Since many of the problems are of a highly personal nature and in view of the fact that the relationship of the individual to the neuropychiatrist is that of *patient* to *physician* rather than of *student* to *advisor*, the handling of such cases will, of necessity, require a somewhat different technic than may be employed by other agencies.

The medical code in general and the neuropsychiatric code in particular is obliged to consider the history and findings in each particular case as "privileged communication." According to Section 325.21 of the Wisconsin Statutes 1943, "no physician or surgeon shall be permitted to disclose any information he may have acquired in attending any patient in a professional character, necessary to enable him professionally to serve such patient except only (1) in trials for homicide when the disclosure related directly to the fact or immediate circumstances of the homicide, (2) in all lunacy inquiries, (3) in actions civil or criminal against the physician for malpractice, (4) with the express consent of the patient, or in case of his death or disability, of his personal representative or other person authorized to sue for personal injury or of the beneficiary of an insurance policy on his life, health, or physical condition."

It is the opinion of Spohn, Ross, Stevens, and Lamb, in a personal communication on this matter, that "the Court has said that this statute is not one of procedure only but is a substantial right and . . . that if any harm come to a patient through any disclosure made by his physician, the patient would undoubtedly have some redress . . .

Apart from a possible civil action by the patient, a doctor may have his license to practice medicine revoked by the Court since Section 147.20 of the Wisconsin Statutes provides that "willfully betraying a professional secret" is unprofessional conduct and grounds for revocation of license.

Thus the doctor finds himself bound not alone by the oath of Hippocrates but also by the laws of his state.

While the privileged communication ruling is designed to assure the patient that his personal problems, illness, or even (upon his direct request) the fact of his visit to the physician, will remain unknown to others, the observance of this ruling is frequently a matter of great difficulty and embarrassment for the physician. This is particularly true on those occasions when others (because of their interest in the case) desire information as to visits or the nature of the malady.

A neuropsychiatrist employed by a university is in a very special manner caught between two obligations, first to the patient in preserving the confidential relationship, and second to the university in the disclosure of pertinent facts which may involve the welfare of the group. Some university psychiatrists have attempted to "solve" this problem by keeping no records whatsoever, so that in event of questioning they can say that they have no notes on the case. It has seemed to us, however, that so drastic a method is unnecessary.

First, on a busy service, it is difficult for the physician to remember each individual case, the point where he left off at the last conference, or even in some instances the nature of the problem itself. This last point has an obviously deleterious effect on the benefits to be derived from therapy since no patient likes to feel that the physician may not recall his case, or that the same problems discussed at the last conference are being rediscussed at the present one in the same manner.

Second, without some record it is hard, if not impossible, to answer legitimate inquiries which may present themselves over a period of time. It has, therefore, been our custom, while placing no psychiatric comments on the student's general health record, to preserve in locked files within the Neuropsychiatric Department, a brief history and progress notes concerning each patient seen by us.

In an endeavor to adhere to a middle course between our obligations to the patient as well as to the university, we have attempted over the past seven years to pursue the following course:

A. The actual history and findings on each patient are regarded as privileged communi-

cation which may only be released as indicated by the statutes of the state, or upon the written request of the patient himself (providing he is of legal age).

B. In those cases where a faculty member or dean has personally advised the student to seek neuropsychiatric help, attempts are made by letter or telephone to inform the source of reference whether (1) the patient has kept his appointment; (2) if he has, whether or not it is deemed possible to aid the student; (3) the approximate amount of time required for such aid; (4) the possible relationship of the patient's difficulty to his school or work program, which often involves recommendations for schedule reduction, postponement of examinations, etc. Such communications are limited to these points unless permission can be obtained from the patient to say more.

C. Very rarely a case presents itself where the privileged communication involves material concerning a public scandal, a serious breach of the moral code involving others so that the welfare and good name of the university might be involved. In such cases, after obtaining a complete history, the relationship of this history to the group is clearly indicated to the patient and every effort is made to obtain his written consent to a disclosure of the pertinent *facts* to responsible university authorities.

D. In cases of this nature, where such written permission cannot be obtained and where it has proved impossible to contact the family of the patient, it is the opinion of our staff, reinforced by interpretation from the Law Department of the university, that the pertinent facts may be laid before the president of the university in his capacity of "pater familias." Fortunately, such a procedure has been required in only one case.

VI. Future

All present signs point to an increase in neuropsychiatric problems. This will be, in part, the result of the outgrowth of an enlarged registration and, in part, because of the adjustment difficulties of student veterans returning to civilian campus life. To meet these increased obligations, the department anticipates an increase in personnel, which will include one full-time neuropsychiatrist, one half-time neuropsychiatrist (whose time will be shared with the personnel and testing services of the university), one full-time clinical psychologist, and one full-time resident neuropsychiatrist.

VII. Acknowledgments

The department acknowledges most gratefully the splendid cooperation and encouragement which it has always received from the medical faculty; the Director of the Psychiatric Institute, Dr. William F. Lorenz; the Director of the Student Health Department, Dr. Llewellyn R. Cole; the offices of the various deans; the vocational guidance and testing departments; and the advisors and the faculty members in general.

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★ *The Board of Medical Examiners will meet March 5 at the Loraine Hotel in Madison to examine applicants for licensure by reciprocity. The Medical Board will meet one day only.*

An Evaluation of the Present Status of Thiouracil Therapy in Thyrotoxicosis and a Report of Its Use in Twenty-Two Cases

By MARIE L. CARNS, M. D. and ROLF F. POSER, M. D.
Madison

M. L. CARNS

Graduating from the University of Wisconsin Medical School, Madison, in 1927, Doctor Carns is associate professor of medicine at the university, and associate physician, Wisconsin General Hospital.

A fellow in the American Medical Association, she is also a diplomate of the American Board of Internal Medicine and a fellow of the American College of Physicians.

A COMPLETELY satisfactory treatment for all patients with thyrotoxicosis has not yet been found. Subtotal thyroidectomy, which has long been widely accepted as the treatment of choice, interrupts a vicious cycle, but does not reach the fundamental cause of the disorder, so it cannot be considered a truly curative procedure. Since Plummer and Boothby,[1] in 1923, introduced Lugol's solution in the preoperative management, the mortality rate and the incidence of postoperative thyroid crises have, of course, been very materially lessened. However, some cases are still serious surgical risks, and usually for one of the following reasons:

(1) Iodine has been used over a considerable period of time, so that the patient has become "iodine fast," and will never again respond optimally to the drug, even after it has been withdrawn for from four to six weeks.

(2) An occasional individual is "iodine resistant" and despite no previous use of the drug, never experiences a satisfactory response. (This is most apt to occur in an extremely thyrotoxic patient.)

(3) The added burden of thyrotoxicosis is thrown upon an already damaged heart, and the patient remains a doubtful risk for surgery, even after optimal preparation.

If surgery is undertaken in these cases, often multiple stage operations are necessary in an effort to avoid severe reactions, and even then a "thyroid storm" may occur in groups (1) and (2).

Obviously, then, any new group of substances having the capacity to decrease the manifestations of thyroid toxicity and to reduce the basal metabolic rate, would be a decided boon to therapy. Such a discovery was unexpected. In 1941, the Mackenzies and McCollum[2] were studying sulfaguanidine and its toxicity to the rat. They noted that it produced an enlargement of the thyroid, with hyperplasia and loss of colloid, and induced a hypothyroid state. In 1942, Richter and Clisby[3] showed that another sulphur compound, phenylthiourea, produced similar results. The following year, Astwood and his co-workers[4] confirmed these experiments and in addition investigated more than 100 related compounds.[5] 2-thiouracil was the most highly active compound tested, although thiourea (which has been more extensively used by English workers) was the least toxic of all. Astwood's priminary report[6] on the administration of thiourea, in daily dosage of 1 to 2 Gm., or of thiouracil, in daily dosage of 0.2 to 1 Gm., to thyrotoxic patients, seemed sufficiently encouraging to warrant further trial.

This report reviews our experience with the use of the drug in 22 patients.* All of our cases presented unquestionable evidences of thyrotoxicosis, the lowest initial BMR being +36 per cent, and in 15 cases being over +50 per cent. Since we feel that the optimal dosage has not been definitely estab-

* Almost all of the Thiouracil ("Deracil") was supplied by the Lederle Laboratories, Inc., Pearl River, N. Y. A small amount was supplied by E. R. Squibb & Sons, New York, N. Y.

lished, and should undoubtedly vary with the degree of thyrotoxicosis and the response, no uniform regimen was employed in this series. The daily dosage (other than for maintenance after a satisfactory response) has varied from 0.6 to 1.8 Gm. daily. Because of rapid excretion,[7] the intervals between doses should be no longer than every eight hours, and possibly even shorter intervals would be desirable, but it is of course particularly important that sleep should not be disturbed in these patients. Three of our patients were treated medically (2 of them having had previous subtotal thyroidectomies) and 19 in preparation for surgery (one case, complicated by pregnancy and agranulocytosis, died before surgery, and in a second case the drug was stopped after five days because of leukopenia). The following table summarizes the outstanding features, and 3 of the more interesting cases are presented in greater detail.

TABLE

Total number of cases treated	22
Sex:	
Females	18
Males	4
Age:	
Varied from 17 to 70 years	
Type of Thyroid Gland:	
Diffuse toxic	13
Nodular toxic	9
Duration of symptoms:	
Varied from six weeks to four years.	
Previous Therapy:	
Iodine	18
Thyroidectomy	2
Radiation of Thyroid	2
Thiouracil (Singly or in varying combinations)	1
None	5
Duration of Thiouracil medication:	
Varied from 24 days to 9 months. (Discontinued in one case after five days because of development of leukopenia).	
Total Thiouracil Dosage:	
Varied from 17 to 126 Gm.	

Case 1.—E. J., a 65 year old woman, was admitted on September 30, 1943, with the chief complaint of loss of weight. In January, 1943, she was diagnosed by her local physician as having a toxic goiter and was given iodine during the following months together with four radiation treatments to the thyroid gland. She derived no appreciable benefit from these procedures. Her outstanding complaints included palpitation, dyspnea on exertion, increased perspiration, and a twenty-pound weight loss in the past few months.

The pertinent physical findings included a flushed, warm, and moist skin, slight exophthalmos with lid-lag and lack of convergence, slight tremor of the tongue, marked tremor of the fingers, palpable thyroid isthmus, pulse rate 130, blood pressure 220/90, an overactive heart with an accentuated mitral first sound and quadriceps weakness.

Thiouracil medication was begun on October 2, 1943. A dosage of 0.2 Gm. three times daily was given for sixteen days, then 0.2 Gm. twice daily for thirty-five days, after which the dosage was decreased to 0.2 Gm. daily for two months and then to 0.1 Gm. daily for two months.

The first BMR was +43 per cent, at which time the pulse rate was 96, the weight 110, and the serum cholesterol 110 mg. per cent. She was discharged fifteen days later, at which time her BMR was +32 per cent, her pulse rate 74, her serum cholesterol 234 mg. per cent, her weight 121 pounds, and her blood pressure 138/74.

She was readmitted three times during the next five months, during which time she continued on thiouracil 0.1 Gm. daily. During this time she experienced very marked symptomatic improvement and on her third admission, approximately six months later, she offered no complaints whatever. At this time her BMR was +3 per cent, her pulse rate 60, her weight 142 pounds, and her serum cholesterol 400 mg. per cent. Thiouracil was discontinuued at this time. She was readmitted on four occasions during the ensuing months, the final admission being on October 8, 1945. During this interval she had felt very well and her BMRs were always within normal limits as was her pulse rate. Her weight further increased to 147 pounds. She remained entirely free of symptoms or signs of thyrotoxicosis and a progress electrocardiogram showed a complete disappearance of a thyrotoxic effect upon the myocardium, which had been present at the time of her original study. She had had no thiouracil for eighteen and one-half months, at the time of her final study here.

Summary: In this case of diffuse toxic thyroid disease, there was a complete control of the thyrotoxicosis on decreasing dosages of thiouracil (0.6 to 0.1 Gm. daily) over a period of approximately six months. She was last studied eighteen and one-half months after thiouracil was discontinued and there had been no recurrence of evidence of hyperthyroidism. She was instructed to return at once if her symptoms recurred and in any event at the end of one year.

Case 2.—A.R., a 37 year old woman, was admitted on January 21, 1944, with a chief complaint of "rapid heart beat." Six weeks previously she had first noted marked weakness and dyspnea, and her local physician had placed her on Lugol's solution (gtt. 10–15 t.i.d.). Because of the development of skin lesions and the lack of any apparent benefit from the drug, it was discontinued after two weeks. She had taken none, then, during the three weeks before her admission. She was experiencing marked

insomnia and irritability, and there had been a weight loss of seventeen pounds.

The outstanding physical findings included extreme restlessness, very warm and moist skin, diffuse thyroid enlargement, fine tremor, quadriceps weakness, pulse rate 142, blood pressure 128/68–0, temperature 100 F. It was felt that her condition was very suggestive of impending thyroid crisis.

The first BMR was +79 per cent and the serum cholesterol 154 mg. per cent. She was placed on thiouracil 0.2 Gm. five times daily. During the first eleven days of therapy she showed slight improvement, her pulse rate being more stable, although tachycardia (rate 100–110) persisted, and her BMR decreased to +59 per cent. On the fifteenth day she appeared strikingly improved, and stated that she had slept well and felt relaxed for the first time. Her pulse rate was 86 and her blood pressure was 126/80. The BMR on the following day was +41 per cent, and her serum cholesterol was 176 mg. per cent. On the twenty-first day, thiouracil was decreased to 0.2 Gm. b.i.d. and she had a subtotal thyroidectomy three days later, at which time her BMR was +33 per cent.

The operative and immediate postoperative courses were extremely satisfactory, but unfortunately the case was complicated by the development of surgical scarlet fever. This cleared satisfactorily on sulfadiazine therapy. Following this, the patient developed a toxic psychosis; the onset was eight days after the last thiouracil medication. Although central nervous system manifestations (such as myoclonic contractions, somnolence, and confusion), have been reported,[8] associated with thiouracil medication, they occurred during the medication and rapidly disappeared with its withdrawal. It seems unlikely that thiouracil played any part in the etiology of the toxic pyschosis in this case. The BMR at the time of discharge from the hospital was +3 per cent.

Summary: In this case of extremely toxic diffuse thyroid disease, in which there was no satisfactory response to iodine, and in which impending thyroid crisis seemed quite possible, there was an excellent response to thiouracil, so that a subtotal thyroidectomy could be performed. There was an unusually satisfactory operative and immediate postoperative course, until an infectious complication arose.

Case 3.—E.W., a 26 year old woman, was admitted on August 2, 1944, with a chief complaint of shortness of breath. One and one-half years previously she had first noted that her thyroid gland was enlarging; six months later she experienced dyspnea, nervousness, and heat intolerance. In June, 1943, a diagnosis of thyrotoxicosis was made and a BMR was +89 per cent. She was placed on Lugol's solution, gtt. 5 t.i.d., which she took for approximately two and one-half months. She experienced so much improvement that she did not return to her physician until February, 1944, at which time the previous symptoms had recurred. She was referred to another hospital in March, 1944, where the previous diagnosis was confirmed, and in addition the patient was found to be pregnant (last menstrual period January 15, 1944). Her BMR at this time was +25 per cent and a biopsy of the thyroid gland was diagnosed as "Grave's disease—Grade III." She was placed on thiouracil, 0.2 Gm. t.i.d., and the following month the dosage was decreased to 0.4 Gm. daily. She continued on this medication until July, 1944, except for approximately one month when she returned home and discontinued treatment against advice. The only BMRs obtained during this interval were in March and April, and ranged from +34 to +22 per cent.

On admission here the patient showed the classical signs of an extreme degree of thyroid toxicity. Exophthalmos was marked, and all of the typical eye signs were present. The thyroid was very large, symmetrical, and diffuse, with a marked thrill and bruit. There was slight cardiac enlargement. The blood pressure was 165/50, the cardiac rate 132 and regular. She was estimated to be six and one-half months pregnant.

The first BMR was too high to be determined, and on repetition a few days later it was +91 per cent. She was placed on sodium iodide, minims two daily, for eighteen days, but there was no significant improvement. She was then again placed on thiouracil, 0.2 Gm. t.i.d. for thirteen days; during this interval one BMR was as high as +125 per cent with a pulse rate of 148; the dosage was then increased to 0.4 Gm. t.i.d. and fifteen days later the BMR was +73 per cent (the lowest ever obtained during this hospitalization). On September 7, a healthy male infant was delivered. On October 13, she developed typical agranulocytosis (the white blood cell count being 1,600 with 16 per cent polymorphonuclears), the temperature soon rising and the throat becoming sore, edematous and ulcerated. Thiouracil was immediately discontinued and the patient was treated intensively with pentnucleotide, crude liver extract, folic acid, two small fresh blood transfusions, and penicillin. For ten days the neutrophiles varied from 0 to 5 per cent(they were entirely absent for four consecutive days), during which time the white blood cells ranged from eight hundred fifty to fourteen hundred. She gradually recovered from this complication and her white blood cell count and differential returned to normal. No sooner was the agranulocytosis controlled, however, than she developed a classical thyroid crisis, with a pulse rate of 160 to 230, and a terminal rectal temperature of 107 F. Despite symptomatic treatment, she survived only three days. The crisis developed twelve days after the discontinuation of thiouracil.

The pertinent findings on post mortem examination were as follows:

(1) Thyroid
Weight 150 Gm.
Hyperplasia (Grave's type)

(2) Bone Marrow
Myelocytic hyperplasia of vertebral marrow.
Aplasia of femoral marrow
(3) Heart
Diffuse myocarditis
Perivascular fibrosis of smaller coronary arteries.
(4) Liver
Weight 1,620 Gm.
Chronic passive congestion
Hyaline necrosis of central zone: fatty degeneration of middle zone, and slight fatty degeneration of peripheral zone.
Irregular portal canals.
(5) Lungs
Patchy bronchopneumonia
Chronic passive congestion
Edema

Summary: In this case of extremely marked diffuse toxic thyroid disease, there was an unsatisfactory control by thiouracil, 57 Gm. being given over a fifty-four day period. The case was complicated by pregnancy which terminated successfully, and by severe agranulocytosis, from which the patient recovered. It is at least possible that thiouracil was controlling her extreme thyrotoxicosis to some degree, as she developed a crisis twelve days after it was discontinued. In retrospect, it seems unquestionable that the treatment of choice would have been subtotal thyroidectomy in the spring of 1944, instead of medical treatment with thiouracil.

Comments

I. Preoperative Medication (19 cases)

1. All of these patients were hospitalized throughout the procedure (with the exception of one who left the hospital for five days).

2. In only two were two-stage thyroidectomies performed.

3. In one case, increased friability of the gland was noted by the surgeon, and in one case increased bleeding. However, these were not considered of serious significance, and in all cases the incisions were closed without drainage.

4. No definite level of the BMR was set as a criterion in deciding upon the time for surgery, as we felt that this decision should be guided by the clinical course as well as the BMR. (It is probable that if thiouracil medication had been continued until the BMR was within normal limits, two-stage thyroidectomies could have been entirely avoided.)

5. The condition during surgery was good in all cases; the postoperative course was entirely satisfactory with the exception of one case, in which a transient leukopenia with neutropenia occurred (described under discussion of toxic manifestations.) In no case was there any suggestion of an impending thyroid crisis.

6. In 12 cases (63 per cent) the response to treatment is evaluated as very good; in 3 cases (16 per cent) as adequate, and in 4 cases (21 per cent) as unsatisfactory. (Three exhibited quite definite evidence of toxic reactions; the fourth was complicated by the menopausal syndrome.)

7. The duration of medication varied from twenty-four to one hundred days, in only 4 cases being one month or less.

II. Medical Treatment (3 cases)

1. In all the response was very good (in one there was no evidence of a recurrence of thyrotoxicosis eighteen and one-half months after discontinuation of the drug.)

III. Combined Series

1. In 3 cases there were toxic manifestations which seemed quite definitely due to the drug. In one case there was severe agranulocytosis, from which the patient recovered, but which may have indirectly contributed to her death in thyroid crisis a short time later. A second case developed leukopenia after being on thiouracil for two weeks. The drug was discontinued for one week and then resumed for eight days, after which surgery was uneventfully accomplished. Four days after the drug had last been given, the patient exhibited a marked leukopenia with neutropenia. Pentnucleotide and penicillin were given promptly and there was a rapid recovery. In a third case, leukopenia developed five days after therapy was begun, and persisted for nine days after the drug was discontinued.

2. In a fourth case, arthritis of the hand and wrist occurred, but the role of thiouracil as an etiologic factor is not established. In a fifth case, a toxic psychosis, for which there was other convincing etiology, occurred eight days after thiouracil was discontinued.

3. We were unable to demonstrate any definite change in the degree of exophthalmos or any consistent or significant change in the

size of the thyroid gland as a result of the medication.

In reviewing the literature on thiouracil therapy, two points are particularly striking: (1) the earlier series were predominantly quite small, and although some of the later series are larger, we still feel that sufficient data of a statistical nature for final evaluation are lacking, and (2) there is an extremely wide difference of opinion among authors as to the usefulness of, and the indications for, the drug; these range all the way from the opinion of Nussey[9] who urges that *all* patients suffering from hyperthyroidism be treated with thiouracil, to warnings such as those of Haler,[10] who stresses that thiouracil is a dangerous drug, which should be given only under the strictest inpatient control. An attempt to summarize advantages and disadvantages should contribute to further helpful evaluation:

Advantages

1. The drug will control thyrotoxic manifestations and reduce the BMR to normal in the great majority of cases, if used for a sufficient length of time.

2. Occasional cases will remain in a remission for at least months after the drug is discontinued.

3. If used as preoperative medication the surgical and post-surgical course is, as a rule, more satisfactory; i.e., less alteration in blood pressure and pulse rate during operation and less disturbance in temperature and pulse rate postoperatively. This can probably be explained by the fact that determinations of the thyroxin content of the thyroid glands of patients treated with thiouracil have shown that only small amounts were present, thus reducing the potentialities for a "thyroid storm."[11]

4. Undoubtedly two-stage operations can more often be avoided in severely toxic cases. As tolerance or refractiveness to thiouracil apparently does not occur, the drug can be administered indefinitely, and the BMR will eventually fall to normal in the great majority of cases. Thus one of the annoying and not infrequent difficulties incident to preoperative preparation with iodine is eliminated, as a necessary postponement of surgery beyond the time of optimal response (most often due to intercurrent infection) does not necessitate withdrawal of the drug and a rest period before a repetition of preparation. (Not infrequently it is necessary to withhold iodine for from four to six weeks, in such cases, and then an unsatisfactory or at least a less satisfactory response is often obtained on repetition.)

5. It offers the best method of treatment yet available in cases of severely toxic, so-called "iodine fast" patients. (We feel that iodine medication in these cases has usually been abused, as it has often been administered continously for many months and occasionally for over a year, despite only, at best, transient early benefit.) These patients respond very slowly to thiouracil, but ultimately successful surgery or continued medical treatment is usually possible.

Disadvantages

1. There are definite toxic effects in a significant percentage of cases, with occasional fatalities.

In 513 case reports sent to the Lederle Laboratories by physicians who had used Deracil, 104 (20.27 per cent) showed toxic side reactions, in 52 (10.14 per cent) of which the drug had to be discontinued. There were 4 deaths (0.78 per cent) attributed to toxicity (3 to agranulocytosis and 1 to acute yellow atrophy of the liver). Any completely accurate statistical data on the exact number of deaths is difficult to ascertain at this time. Haler[10] wrote in the British Medical Journal of March, 1944, that "at least a half dozen fatal cases of agranulocytosis due to thiouracil have been described," and reported the necropsy on one case of his own; however, he gave no details and no references. Newman[12] stated in the Medical Clinics of North America of March, 1945, that "there have been at least seven fatalities from agranulocytosis," and included Haler's brief report in his bibliography. We have been able to find definite reports of 4 deaths from agranulocytosis in our available North American literature.[13, 14, 15, 16]

In the Lederle series of 513 cases the frequency of toxic reactions attributed to the drug occurred as follows:

Leukopenia	6.23%
Nausea and/or vomiting	3.7 %

Hyperpyrexia	3.5 %
Dermatitis	2.92%
Agranulocytosis	1.94%
Pruritis	1.55%
Headache	1.37%
Vertigo	1.11%
Jaundice—Liver Damage	0.97%
Adenitis	0.78%
Diarrhea	0.58%
Joint pains	0.39%
Anemia	0.19%

2. In preoperative preparation, a longer period is usually necessary than in cases in which there is a satisfactory response to iodine. This has been found to be the case especially in large toxic nodular goiters.

3. Close medical supervision and adequate laboratory studies are necessary as long as the drug is used.

Fishberg & Vorzimer[17] recommend that in every case in which more than 0.2 Gm. is administered daily, it should be a fixed rule that a white blood cell count be made every three days, and a differential count if there is over 20 per cent drop in the total number of leukocytes. If the maintenance dose is reduced to 0.2 Gm. or less daily, and the leukocyte count has remained within normal limits, they feel that the interval between white blood cell counts may safely be lengthened to every two to three weeks. However, in view of the fatal case of agranulocytosis reported by Gargill and Lesses[16] in which death occurred during a third course of thiouracil, on a dosage of only 0.2 Gm. daily for four weeks, it appears that previous freedom from any demonstrable toxic effect and the use of the small, so-called maintenance dosage, is no guarantee of safety, and that frequent blood counts are still necessary. Also, difficulty in the interpretation of values may arise because of the tendency of thyrotoxic patients to have a slight leukopenia with a low percentage of neutrophiles. Newman[12] recommends that the leukocyte count be followed at daily intervals if the total count is as low as four thousand, or the differential count shows a fall of neutrophiles to 40 per cent, and that the drug be discontinued if the total count declines to thirty-five hundred or the differential to 30 per cent neutrophiles. We agree with these recommendations.

4. Late effects may conceivably follow its prolonged use.

a. Depression of the bone marrow.

b. Development of benign or malignant neoplasms or of atrophy, following a chronic hyperplastic state of the thyroid.[18]

c. Disturbance of thyroid pituitary balance with hyperfunction of the pituitary and eventual exhaustion.[19]

5. Possibility of surgical difficulties.

The reports here are quite conflicting. Bartels[20] states, "the technical difficulty which the surgeon encounters in removing the thyroid glands of patients who have received thiouracil is extremely great. On opening the skin, excessive bleeding occurs and the gland is found to be extremely soft and friable. It is difficult to isolate the recurrent laryngeal nerves and the parathyroid glands, which our surgeons wish to see." On the other hand, the surgeons reported no significant difficulties in our series, and many articles omit any reference whatever to any significant surgical difficulty.

6. Development of myxedema.

This is apparently rare, and not difficult to control.

In attempting to evaluate the indications for the drug on the basis of the available information to date, it would seem to us that it is definitely useful in the following conditions:

As preoperative medication: (1) in the "iodine fast" or occasional "iodine resistant" individual; (2) in cases of extremely severe thyrotoxicosis, of the type in which iodine produces some improvement but often effects an inadequate response for subtotal thyroidectomy, thereby necessitating multiple stage operations.

In addition, it may be indicated: (1) in certain cases in which there is a definite contraindication to surgery, because of complications, but it is at least doubtful if it will prove as valuable as properly administered radiation. (It is possible that a combined treatment here, until the even slower response to radiation is achieved, may occasionally be useful); (2) in certain cases of recurrent thyrotoxicosis, especially if there is no identifiable thyroid tissue, or possibly in the presence of a deep substernal thyroid, although its desirability here as against further surgery or radiation is debatable; (3) in acute thyroiditis.[21]

We doubt its suitability for protracted medical treatment for the following reasons: (1) the significant danger of serious toxic reactions, especially on the bone marrow and less frequently on the liver (to date these reactions have been unavoidable and unpredictable); (2) the close supervision necessary throughout its administration; (3) the lack of knowledge as yet as to its possible delayed effects; and (4) inasmuch as it produces hyperplasia of the thyroid gland, the improbability of a permanent medical "cure." In the last regard, the opinion recently expressed by Rawson[20] seems pertinent: "I do not believe that the evidence is adequate to conclude that thiouracil is a medical cure for thyrotoxicosis. A medical cure will, I think, have to attack the primary pathologic physiology of the disease. I do not believe that thiouracil does that any more than surgical removal of the thyroid."

Suggestions for the avoidance or treatment of the side reactions of the drug include the following:

I. To lessen excessive bleeding if thyroidectomy is performed.

A. Use of a Vitamin K preparation three days pre- and postoperatively. However, as a rule, no real difference in bleeding, clotting, or prothrombin time between thiouracil-treated patients and normal controls has been found.[22] Occasionally the prothrombin time has been somewhat increased in patients on thiouracil therapy,[11] but this is probably a rare cause of bleeding.

II. To decrease the friability of the gland (in addition to the prevention of excessive bleeding).

A. The use of iodine (with thiouracil) preoperatively. This has been favorably reported upon by several authors. If iodine was administered during the last two or three weeks of thiouracil preparation, it was found that a remission of thyrotoxicity could be obtained as readily as if only thiouracil were used, yet there tended to be somewhat less bleeding and friability of the gland.[11]

III. To prevent a transient enlargement of the thyroid gland (frequently noted by many observers during the first week of thiouracil therapy); also in the management of any pitting edema present.

A. Thyroxin, grains 1/320 to 1/160, or dessicated thyroid, grains 2.

1. At the beginning of treatment to all patients showing exophthalmos or other eye signs.

2. To non-exophthalmic cases later, after the basal metabolic rate has begun a sustained fall.

This has been reported to have no appreciable inhibitory effect on the action of thiouracil in lowering the basal metabolic rate.[22]

IV. To prevent possible renal complications.

A. The use of ten grains of sodium bicarbonate with each dose of thiouracil, since the drug is soluble in an alkaline medium (PH8.5). Palmer[22] reported the occasional occurrence of crystalluria and even microscopic hematuria before this procedure, but not since using it.

V. To counteract a depressant effect on the bone marrow.

A. Cevitamic acid, 100 mg. daily.

B. Thiamine or brewer's yeast.

C. Vitamin B–6 (pyridoxine).

Cantor and Scott[23] found that patients with toxic granulocytopenia (principally developed following sulfonamide or thiouracil therapy) showed a rapid and sustained rise in the leukocyte count and a marked increase in granulocytes on pyridoxine therapy. Fishberg and Vorzimer[17] feel that 200 mg. intravenously, where a severe drop in the leukocyte count has occurred, seems at present to be most promising.

In general, the precautions to be observed are very similar to those which should be employed in the careful administration of the sulfonamides. If the patient is treated at home, he should know the name of the drug and be instructed to report this to any physician he may consult in the interval, also reporting to him that he has been instructed to take no sulfonamide drugs or other compounds containing the benzene ring, and he should be given only two or three days' supply at each visit.

In an evaluation of the status of thiouracil therapy at the present time then, it seems wise to remember that if iodine is *properly* used, the majority of individuals with hyper-

thyroidism respond satisfactorily and thyroidectomy can be performed with little risk (the mortality is 1 per cent or less in the better clinics today). Also, carefully supervised programs of radiation have proved very successful, in our experience, in selected cases in which surgery was contraindicated. Much more study seems necessary before these time-proven methods should be wholly or considerably replaced by thiouracil therapy. For the present, we feel it is indicated only in a limited number of cases; but if carefully supervised, it offers the best preoperative preparation in these selected cases. This opinion may well have to be revised should a similar drug, devoid of the possible serious toxic reactions of thiouracil, be found, or should a means of desensitizing patients to the drug or of definitely successfully counteracting the toxic reactions, be discovered.

Summary

Observations in 22 cases treated with thiouracil have been presented. The number is obviously much too small to be of any statistical significance in itself. However, the *final* evaluation must come through the summation of the experiences of many observers. An evaluation of the present status of thiouracil therapy, based on our experiences and those reported in the literature, is offered.

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BY-LAWS, CHAPTER VIII, SECTION 1

". . . *Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the secretary of this Society on or before March 31 shall stand suspended until his name is properly reported and his dues for the current year properly remitted.*"

Shock in Forward Areas

By LT. COL. JAMES M. SULLIVAN (MC), AUS
Milwaukee

J. M. SULLIVAN

Doctor Sullivan was graduated from the Marquette University School of Medicine in 1932. He attended the University of Pennsylvania Postgraduate School of Medicine in 1936. A diplomate of the American Board of Surgery and a fellow of the American College of Surgeons, Doctor Sullivan served in the armed forces over four and a half years.

THIS paper has been prompted by our experiences with over 400 cases operated on by the author in the Tunisian and Italian Campaigns, as the operating surgeon on a general surgical team of an auxiliary surgical group working in forward areas in installations equipped to do major surgery. Shock was found to be the greatest single cause of death.

Our conception of shock, stripped of excessive verbiage and for the moment not being concerned with the various theories of its production, is that the essential part, and that portion of the cycle susceptible to treatment is the circulatory collapse characterized by an oligemia, which goes on to a tissue ischemia, anoxia, increased capillary permeability, and further loss of intravascular fluid—the well-known cycle which leads to death.

Forward installations such as clearing stations and field hospitals equipped to do initial surgery, by reason of their being augmented by auxiliary surgical teams, are concerned mainly with those casualties which come under the terminology of non-transportables. Eighty per cent of our cases were in moderate or profound shock on arrival. By a moderate degree of shock we mean a patient with a blood pressure of 80 to 100 systolic. A patient with profound shock has an almost absent blood pressure or does not exceed 50 mm. of mercury, a thin, thready, or imperceptible radial pulse, an ashen grey color, and either conscious or semi-conscious, the extremities being cold and clammy. It is remarkable how long these patients remain conscious in spite of their circulatory collapse.

The type of case under discussion is invariably due to both trauma and hemorrhage, and may have several other complicating factors. The cases due to trauma of a mild or moderate nature, psychic shock, etc. we will leave for other discussants. Although we are fully cognizant of their occurrence and have seen our share of them, our most difficult problems have been from cases of the profound shock mentioned.

The diagnosis of shock itself is almost immediately obvious by inspection alone, but in order to estimate its severity and plan its treatment, something more is necessary than to see the casualty and to know his pulse and blood pressure. The extent and site of the wounds, the possibility of continued active bleeding, all help to estimate the amount of shock present. The presence of complicating factors such as gas gangrene, peritonitis, blast injury of the lung, and cerebal injury also have an important bearing. Treatment can and should be started at the earliest possible moment, but the complete diagnosis should also be arrived at early in the course of treatment. Unnecessary exposure and manipulation is obviously not intended. The taking of x-rays or fluoroscopic examinations should be delayed until the patient shows some response to the resuscitation measures and if possible may better be delayed until the maximum benefit has been obtained.

The treatment of these severely shocked cases as far as general measures are concerned resolves itself into oxygen, blankets to prevent further loss of body heat, the shock position, plasma, blood, and if dehydration is marked, saline solution. Morphine has usually been given before we received the casualty and in such doses that it rarely

is repeated before the operation. Our experience with stimulants and vasoconstrictor drugs leads us to believe they are of limited value in these severe cases. Local treatment such as reapplication of turniquets or pressure dressings to stop visible bleeding, resplinting, or reapplication of traction for fractures etc. is not neglected. Paracentesis of the chest or pericardium both for the purpose of diagnosis and treatment frequently aids the resuscitation.

The estimation of the amount of treatment necessary for each individual case taxes the ingenuity and experience of anyone to the utmost. The surgeon must accept his full responsibility and not leave it up to the shock officer to determine this critical point. Only by complete teamwork can a successful outcome be achieved. The response of the patient to treatment as detected by his color, turgor, blood pressure, and pulse aid in estimating his needs. The pulse is a more sensitive index than the blood pressure and requires much more time for its stabilization. After the blood pressure and pulse have been improved they frequently will not hold this improvement until more treatment is given. Hematocrit estimations are of great value if available. The relation of plasma to blood given is a frequent question and one that has been in a state of flux during this present campaign; the present tendency is to place our chief reliance on blood.

The typical case is started off immediately on plasma while he is cross matched for transfusion. He frequently has had 2 to 4 units of plasma in the battalion aid station or enroute before we get him and therefore we switch over to blood as soon as it is available. Since we have had refrigerated blood available this has greatly facilitated the treatment. Two to four 500 cc. bottles of blood are then given rapidly and it has been our experience that if the patient does not respond to this his chances of survival are almost nil. Two more transfusions are kept on hand for the operating room and postoperative treatment. The amount of blood given is arrived at from experiences with each type of case. We know that in an abdominal injury we usually find from 1,000 to 1,500 cc. of blood in the abdominal cavity. Bilateral amputations usually require from two to four transfusions. These figures are not given to be used as a rule of thumb by any means, but are only approximate averages we have come to recognize. The over all diagnosis must determine in each case what is to be used. We have given as high as ten transfusions before operation, but unless there is continued bleeding this is very unusual. Since bleeding, be it either external or internal, is the dominant cause of the shock we are dealing with, blood replacement has come to play a more and more dominant role. Oxygen is also given continuously to increase the efficiency of the depleted RBC's.

Optimum Time of Operation

Judging the optimum time of operation is even more difficult than the amount of treatment necessary. This becomes almost wholly the responsibility of the surgeon as he alone knows the difficulty of the procedure to be done, his ability and speed in performing it, what relaxation will be required, etc. The anesthetist should also aid him in his decision by helping to evaluate the patient's ability to withstand the necessary operative procedure and anesthetic. An attempt is always made to get the patient's blood pressure up to or above 80 systolic and his pulse down to 120 or lower. The patient should also be stabilized sufficiently so that it is possible to move him into the operating room without the blood pressure taking a sudden drop and the pulse increasing. If this happens, the operation should be delayed until more resuscitation is given.

Under adequate and rapid treatment, if the expected improvement is not produced within a period of three or four hours, further complications must be sought for an explanation, such as continued bleeding, peritonitis, gas gangrene, blast and cerebral injury. It is understood that the treatment of tension pneumothorax, hemothorax, hemopericardium, etc., constitute part of the shock treatment.

If the patient cannot still be brought into suitable condition for operation we attempt the surgical procedure indicated anyway, continuing resuscitation during the operation as this is the only chance these patients have for recovery. Surprises are frequently en-

countered. A case of a lacerated spleen is recalled in which we were unable to raise the blood pressure above 70 systolic, but nevertheless proceeded with a laparotomy. As soon as the spleenic pedicle was clamped, the blood pressure improved while the patient was on the operating table and he went on to a complete recovery. Another case in which there were numerous holes in the small intestine and tears in the mesentery followed a similiar dramatic improvement when the holes in the viscus were closed and the mesentery sutured, this in spite of the fact that there was no severe bleeding present. Out of 75 abdominal cases, the great majority of which were in severe shock, we refused to operate in only 2 cases. One had a perforation of the stomach received forty-eight hours before admission and was practically moribund. Constant gastric suction was applied with a Levine Tube and his shock treated vigorously, but he failed to rally and expired within eighteen hours. The other case had a perforating wound of the lower left abdomen with a perforation of the anterior portion of the sigmoid colon. He had been wounded five days previously and was in only moderate shock. Under conservative treatment he made a full recovery.

Anesthetist Important

Treatment during the operation is primarily in the hands of the anesthetist as far as resuscitation procedures are concerned. Customarily one or two transfusions are going or immediately available with a vein already canulated. During the operation we are always on the alert for a sudden severe loss of blood which may occur by forcing a clot from a severed artery before it is exposed sufficiently to control it. In one of our cases in which the inferior vena cava had been severed, freeing of the right colon and parietal peritoneum released the tamponading effect of the hematoma and before the bleeding could again be controlled a tremendous amount of blood was lost. Being able to replace this blood rapidly is frequently life saving. Pentothal and spinal anesthesia, we feel, have no place in these cases because of their tendency to increase the shock. Endotracheal ether has proven to be our mainstay. As high an oxygen content as possible is desirable in the anesthesia used and the depth of anesthesia should be as light as is compatible with the work to be done. We frequently use combinations of local and general anesthesia to achieve this purpose such as intercostal and regional nerve blocks, etc.

Gentle handling of tissues and sharp dissection together with rapid work lessens the amount of shock caused by the operation.

Postoperative Treatment

Treatment postoperatively resolves itself into the usual measures used for the pathology found at operation with more vigorous prosecution and more attention to detail. It should be remembered that these patients have received tremendous quantities of fluids and the bladder should be watched to determine the necessity of catheterization even before the patient has reacted from his anesthetic. The giving of too large a quantity of fluid with the production of pulmonary and peripheral edema is also to be avoided. We have found that daily transfusions are frequently necessary for several days to maintain the hematocrit at a normal level.

A blood bank is an immeasurable aid in doing this type of surgery. During the cold weather outside storage may be used, but a refrigerator is the ideal storage vehicle. A preponderant number of "O" bloods of low titer will permit transfusions even without typing when the occasion arises. High titer "O" blood will occasionally give reactions especially when given to "A" recipients.

A whole chapter might be written on the technic of intravenous therapy especially on patients with almost complete circulatory collapse. The jugulars, the femoral vein, the corpora cavernosa, and the sternum are routes to be considered when other ways have been exhausted. The technic of sternal infusions is easily mastered and a fairly rapid flow can be obtained. Lacking proper needles, we took 16 gauge needles, cut them down to $1\frac{5}{16}$ inches, fitted them with a hub from a spinal needle, and then inserted a stylet. Once the intravenous set up is working it can be speeded up by attaching a blood pressure bulb to the air vent of the solution

and applying back pressure. By this method 500 cc. of blood can be run into a patient in a remarkably short period.

We have seen several cases of anuria develop in these severely shocked cases and although we feel the prolonged shock is the prime causative agent large doses of the sulfonamides given while the patient is in shock may have an accumulated absorption when he becomes resuscitated and result in precipitation of the crystals. The possibility of the many transfusions and the rapidity of administration being an etiologic agent in some cases is also recognized.

The effect of cold on shock has been interesting. We have noticed that if we warm these patients up too rapidly before plasma and blood have been started they respond very poorly. During the winter months when a great deal of the fighting was being done in the mountains and evacuation was long and difficult we were amazed at the length of time some of the casualties had been in profound shock and were still living. The cold of course may reduce the metabolism and thus permit life to continue in spite of the shock. Because of these observations we believe excessive heat is to be avoided until the oligemia is or has been corrected.

Conclusions

1. We have presented our experiences and clinical impressions of the profound shock we have observed in forward installations receiving battle casualties.

2. Resuscitation measures have been aimed primarily at correction of the oligemia present in shock.

3. Blood supplanted plasma more and more as time went on and it became more readily available for the treatment of these casualties.

4. The treatment of these severe cases of shock requires the combined teamwork of the shock officer, the surgeon, and the anesthetist.

5. After adequate resuscitation measures have been used for three or four hours and the casualty is still not in suitable shape for surgery, operation is performed in an attempt to correct the injury as a desperate gamble.

6. Failure to respond to adequate shock therapy is indicative of the presence of complications such as: active bleeding, peritonitis, blast or cerebral injury.

7. Anuria may be produced by prolonged shock.

8. Excessive external heat is to be avoided in profoundly shocked cases until the oligemia has been corrected.

Addenda

Recently, laboratory procedures such as specific gravity determinations of blood, hematocrit, sulfonamide determinations, and serum protein estimations have been made available to hospital installations in forward areas. This should do much to increase our knowledge of shock and aid in its treatment.

SCARLET FEVER RULE REVISED

The State Board of Health at its January meeting amended the rules on scarlet fever. This action was taken because of the increasing mildness of the great majority of cases in recent years. Formerly the rule required children with the disease to remain out of school six weeks from the onset, even though the quarantine had been taken off the premises prior to that time. The present rule deletes this provision and allows school children to return to school when the quarantine sign is taken off. A minimum quarantine period of three weeks is still required.

In complicated cases which have been under quarantine for a long period of time, the new regulation states that three or more consecutive negative tests for hemolytic streptococci, taken at intervals of not less than 24 hours, examined in an accredited laboratory, may be considered evidence of non-communicability in complicated or apparently infectious cases.

Copies of the revised rule have been mailed to all local health officers in Wisconsin and interested physicians may obtain copies by writing to the State Board of Health, Madison, or may get details from the local health officer.

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Blood Transfusion Malaria in the Post-War Period

In most tranfusion malarias reported in the United States the donors were in a latent period of quartan *(P. malariae)* infection acquired years before in the Mediterranean countries from which they had emigrated. For example, Rubenstein *et al* (1945) showed that of the 12 cases reported in Massachusetts since 1929, 9 (possibly 10) were caused by *P. malariae* latent in 5 of the donors for from twelve to twenty-seven years. However, in the post-War II period we shall have as potential donors returned soldiers infected with the benign tertian organism *(P. vivax)*, which practically alone is being brought back to this country. The number of such individuals will be large, since an Army report in November, 1945, stated that the diagnosis of malaria had been made in nearly 500,000 instances in that force alone. Some soldiers will also come home ostensibly malaria-free, the first evidences of infection appearing long after their return.

How long will these *vivax* infections last? Pre-war experience dictates the answer that the last relapse will occur before the end of the second year, though Boyd (1944) admits the possibility up to three years. But this knowledge may not tell us what to expect in soldiers from the South Pacific, for Coggeshall (1945) reported long courses for this malaria; 57 per cent of the men observed by him had more than 14 attacks and some as many as 40. So there exists the likelihood that much returned-soldier malaria may persist for a period not definitely predictable.

How determine whether an individual is uninfected? The answer is that this determination cannot be made with certainty. Prolonged study of a thin smear may reveal an organism or two in an apparently well individual, and if trained personnel is available the study of a thick drop will about treble the likelihood. But negative findings do not rule out the disease; indeed donation may bring organisms into the blood of a negative individual. Therefore, for many years following his return from overseas we cannot safely use the blood of a soldier known to have had malaria. Nor may we use the blood of one who returned apparently uninfected, for Coggeshall saw a first attack eight months following withdrawal from an endemic area and mentioned another authentic instance in which the period was thirteen months.

Will malarious blood lose infectiousness through storage? Hutton and Shute (1939) answer that all species of plasmodia survive for weeks at usual storage temperatures. McClure and Lam (1945) reported 2 patients infected with blood refrigerated five days. However, Antschelewitsch (1937) failed to transmit the disease in all eleven instances in which he stored known malarious blood more than eight days.

How protect the patient if obliged to use known or suspected malarious blood? If this donor is given full therapeutic dosage of quinine or atabrine for as long as feasible before the donation transmission may possibly be prevented, though I am unable to cite substantiating evidence. Thoroughman (1940) gave quinine, 5 grains (0.3 Gm.) three times daily for three days following transfusion of malarious blood in 34 cases; no malaria developed though the disease occurred in 35.6 per cent of the untreated recipients of blood of similar donors.

Summary: (a) the blood of a soldier returned from an endemic area should not be used whether or not he is known to have contracted malaria; (b) if such blood must be employed under exceptional circumstances it may possibly be rid of plasmodia by storage beyond eight days; (c) an individual transfused with malarious blood is possibly protected by treating him for the succeeding three days.—HARRY BECKMAN, M. D.

Notes on Clinical Pathology

Editors—Walter H. Jaeschke, M. D., University of Wisconsin, Madison and
S. B. Pessin, M. D., Marquette University, Milwaukee

Introduction

The Council on Scientific Work has granted a regular section in the *Journal* to the Wisconsin Society of Pathologists. This section, entitled "Notes on Clinical Pathology," will deal with clinical laboratory procedures and interpretations, pathogenesis of disease, and pathologic anatomy. We will attempt to clarify the function of a clinical laboratory in the fields of hematology, medical chemistry, bacteriology, mycology, parasitology, serology, neoplastic diseases, metabolism, surgical pathology, and necropsies.

The modern clinical laboratory should be considered one of the important departments of medicine from which aids to diagnosis, treatment, interpretations of disease, research, and teaching emanate. No laboratory can progress if the clinician considers this department composed of one or several rooms containing technical paraphernalia, managed by a hide-and-seek super-technician and assisted by a few lesser technicians whose duties are to turn out blood counts, urinalyses, simple chemistries, and serologic tests. It would be wasted energy for the clinical laboratory to develop various special tests if the clinician merely is satisfied with a few blood counts and urinalyses, and never requests other laboratory examinations for his patients merely because he either has not heard of certain special tests or does not know how to interpret them.

The scope of laboratory studies is almost unlimited. There are, however, a moderate number of well recognized diagnostic laboratory procedures, the use of which are too often neglected. If the clinician would intelligently employ the laboratory service, diagnostic problems in various anemias, jaundice, infections, chemical disturbances of the body, etc., would be more readily brought to light. It is not always necessary to hospitalize a patient for laboratory studies if the physician understands the type of laboratory work essential for a particular case and if he is capable of properly collecting the specimen to be examined. We will attempt in the future issues to instruct the proper collection and care of specimens.

The contributors of this page will be the members of the Wisconsin Society of Pathologists, and it is hoped that all of them will respond to the demand for clinical laboratory interpretations by contributing regularly to this department.

The active members of the Wisconsin Society of Pathologists are: Drs. E. F. Barta, J. F. Kuzma, N. Enzer, G. H. Hansmann, S. B. Pessin, J. J. Seelman, E. L. Tharinger, L. J. Van Hecke, Milwaukee; W. H. Jasechke, L. McGary, G. Ritchie, W. D. Stovall, Madison; J. L. Ford, Green Bay, and W. E. Bayley, in service.

Recently settled pathologists in Wisconsin who are not yet members are: Drs. W. A. D. Anderson, Milwaukee: M. Angevine, Madison; O. Kanner, La Crosse; J. Pasternack, Madison; T. S. Rosen, Eau Claire; and G. A. Walker, Racine.

All pathologists listed are diplomates of the American Board of Pathology.—S. B. P.

As It Looks to Your State Board of Health

(These timely discussions of health problems are prepared by staff members as a special service to Wisconsin's physicians.)

Public Health Nursing and You

Doctor, how much do you know about public health nursing? Here is the largest group of public health workers. They daily contact more of the public than any other health personnel. They are the G.I.'s of the public health army—they do the spade work. In the twentieth century they, like you, have played a major role in helping to reduce death rates.

To attempt to describe the work of the public health nurses in this brief space would be an injustice to them. You should know, however, that public health administration places a high value upon their services and depends upon them for much more than merely rounding up the children for immunization clinics. Here are the highlights of their work which touch you most closely:

Case Finding

The public health nurse discovers illness and disease in their natural habitat—the home. In tuberculosis, for instance, she is frequently the first to suggest a chest x-ray. When the suspected case has been brought under medical care she teaches the family how to care for the patient and to protect itself. She makes arrangements for sanatorium care, sometimes after long persuasion of the sick one and his family. The nurse breaks the chain of infection by close follow-up of all the patient's contacts, and helps the contacts carry out recommendations of the family physician. She continues to follow up the patient after discharge from the sanatorium to prevent reactivation.

Interpreting Your Orders

The program of infant and maternal health needs the public health nurse. Suppose the pregnant woman fails to show up for your suggested monthly visit? No one expects you to go out and bring her in, yet her ignorance, apathy, or both may result fatally for mother and infant. To the public health nurse has been delegated the task of contacting expectant mothers, explaining the importance of early and continuous medical supervision. Or you may order "a good general diet"—words which are practically meaningless to the average patient. For you to have to explain the fundamentals of an adequate diet would require time you do not possess, and with one eye on the clock and the other on a waiting room full of fidgeting patients you would probably flunk the job. So the modern physician avails himself of the cooperation of the public health nurses.

Health Education

Every visit of the public health nurse is a personally-conducted lesson in health and hygiene. No other means of health education has been found as effective. As she shows the mother how to sterilize the baby's bottle or isolate a child with chickenpox from the rest of the family, the public health nurse brings home the fundamentals of disease prevention and health maintenance.

Each county public health nursing service is directed by a committee, one member of which is the district health officer. In most instances the committee includes a member of the county medical society who serves in an advisory capacity. Not only the medical society representative but each practicing physician should familiarize himself with the nursing program, and offer suggestions and guidance.

Public health nursing has proved its worth, in spite of the fact that it has been spread very thin. A recent survey in the Fond du Lac Sanitary District showed a ratio of one nurse to 24,000 population in the rural areas, each nurse covering an area of nearly 500 square miles. Most Wisconsin counties employ only one county nurse, even those with populations of 30,000 or more. Recommended ratio by the American Public Health Association is one nurse for each 5,000 population. You, doctor, can carry great weight in influencing your community to make provision for more complete public health nursing services.—MARSHALL W. MEYER, M. D., *District Health Officer.*

As It Looks to the American College of Radiology

Wisconsin is but one of many state, area, or specialty medical societies. Its perspective is that of a mid-western state. But its problems, at least in part, are also problems elsewhere. These pages are provided periodically for the reactions of medical leadership in other parts of the country.

M. F. CAHAL

Mr. Cahal began his work with organized medicine as executive secretary of the Sedgwick County Medical Society, Kansas. He became executive secretary and general counsel of the American College of Radiology in 1937. He is an Associate Fellow of the American Medical Association and a member of the Illinois Bar and the American Bar Association.

As it looks to the American College of Radiology, the medical profession in America has a single course open to it. Any casual reader of medical literature and the writings of political economists during the past ten or fifteen years cannot fail to be aware of a growing demand for improvements in the distribution of medical services. These insistent demands, revealed by at least a half dozen authoritative polls of public opinion, cannot be ignored.

Events of enormous significance are stirring, throughout the world. Perhaps those who refer to them as manifestations of a powerful social revolution are not far from wrong. Certain it is that in this and other English-speaking nations, new economic and political theories, answering the increasing exigencies of society, have created currents within and about the medical profession that are testing its very foundations. It seems unlikely that the system of medical practice as we have known it in this country will be left unchanged when the currents subside.

For at least fifteen years doctors have been discussing proposals for the application of the insurance principle to payment for medical costs. During the course of these debates, practically every county medical society president has, at some place in his annual presidential address, repeated the familiar warning that. "Either the medical profession must do this job, or someone else would do it for us."

Now, the President of the United States has proposed that the Federal government shall do the job, and his recommendations have been implemented by adroitly written legislative proposals. Thus, the time for admonition seems to have passed; it should be clear to all that the palpable demands of the ephemeral public for medical insurance must be met by action.

As is the case with all great social and economic innovations, proposals for changes in the manner of meeting the costs of sickness are surrounded by controversy, confusion, and complexity.

But paramount to all other questions involved is the question of whether prepayment for medical care shall be voluntary or compulsory. In relation to this issue, all other questions become minor, such as whether benefits shall be in cash or in kind, whether income limits shall be imposed, and whether the chief objective of medical insurance should be protection against catastrophic sickness or complete medical care.

If the voluntary approach is to prevail, and the freedom, growth, and advancement of American medicine thus be preserved, organized medicine must extend without delay the present coverage of voluntary medical insurance plans sponsored by medical societies.

We in the American College of Radiology have watched with interest the development of Wisconsin's experiment. Somewhat belatedly, the American Medical Association has encouraged the development of a national plan, under medical control. These are encouraging signs.

Medicine can marshall convincing argument to support its contention that the voluntary method is superior to the compulsory

(Continued on page 272)

. . . . THE PRESIDENT'S PAGE . . . .

Better Care For the Helpless

THE measure of a civilization is best determined by the treatment accorded the sick, the aged, and the helpless. Primitive peoples abandoned the infirm to the weather and predatory animals; the wild animals of forest and plain live only while they have the strength to gain subsistence for themselves.

In our time it appears that we have not advanced in humanitarianism as we have in utilitarian devices and showy constructions. We make things easier for the virile by our promotions and think of education in terms of ornate architecture and schooling for paper credentials. Air ships span the skies, the roads are ribbons of concrete, our architecture is imposing; but by dreary contrast the care of the old and the incapacitated is continued from decade to decade without change or improvement if they are so unfortunate as to require community or state aid. Many charitable individuals and associations have sensed this indifference and have contributed what they could to better the situation. Legislatures are subjected to the pressures of many groups; but the incapacitated members of the community have no lobbies to represent them.

A proposal to extend state aid to all persons in the state who are so completely disabled as to require continuing personal care was made at the 1945 meeting of the House of Delegates of the State Medical Society. This proposal was referred to the appropriate committee of the House which referred it back favorably. The House of Delegates voted adoption of the report.

In the meantime the county judges of the state, who are also closely acquainted with the problem, appointed a committee to confer with a committee from the State Medical Society that preliminary work may be started for presenting this problem to the Legislature of the State of Wisconsin at its next session.

Such a measure should empower the county judges with authority to work out the will of the Legislature. Consideration should be given to the manner of extending relief, either by the authorization of state hospitals for the purpose or by utilizing private hospitals that can furnish proper facilities and nursing, or by both. The committee from the State Medical Society has been appointed. I think we may feel confident that the conference of the committees will produce a program that will point to something better than has been accomplished heretofore for the helpless.

P. R. Minahan

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« « « EDITORIALS » » »

Introducing the Guest Editorialist

THE medical profession of Wisconsin continues to be honored by those who graciously present a guest contribution for the editorial page of *The Wisconsin Medical Journal.* The *Journal* takes particular pride in presenting to its readers one who needs no introduction to Wisconsin physicians—the Reverend Anthony F. Berens, S. J., a faculty member of Marquette University, and its medical school regent. Father Berens, in his eighteen years with Marquette, has acquitted himself and the institution he serves with great credit to both.

No stranger to Madison, Father Berens is one among many who have joined to explain before legislative bodies the necessity of experimental laboratory procedures. His wit, his imperturbability, his mastership of the art of logic, and his dignity have distinguished him as a leader among men. It is particularly fitting that as medicine embarks upon new periods of concern, Father Berens should present a contribution to this *Journal.*

Unity, Peace, and Concord

SIR WILLIAM OSLER, in 1905, bade farewell to the medical profession of the United States in an address which was most characteristic of his kindly disposition. He entitled his talk "Unity, Peace, and Concord" and introduced it in Aequanimitas with two quotations, one of which was "In necessariis, unitas, in non-necessariis, libertas, in omnibus, caritas" ("In essentials unity, in non-essentials, liberty, in all things, charity.")

Would that the amiable, wise, and eminent physican who, on leaving this country, could say "So far as I can read my heart I leave you in charity with all" could move among us for a time and implant his own love of unity, peace, and concord throughout the medical profession in this state. At the very time that the welfare of the practice of medicine is most endangered, the members of the profession in Wisconsin are most disunited. Divide and conquer is a commonplace of welfare, but unfortunately our physicans have gratuitously yielded this advantage to their enemies.

In this same address, Osler quoted the following excerpt from a letter he had received from a friend: "I must say to you that one of the most distressing bewilderments of the layman who only desires the working out of a broad plan is the extraordinary bitterness of professional jealousy . . . which makes it extremely difficult for the layman to understand what way there is out of these squabbles." I have often heard very similar views expressed by highly intelligent friends who were most partial to organized medicine. To many of us who are not actually members of the profession but who are most interested in the preservation of the private practice of medicine, and who therefore are pained and astounded at this continued and growing disunion, it is all too evident that what the Wisconsin medical profession stands most in need of is a thorough self-examination of conscience. Each individual member should make a humble self-appraisement as to whether he has sought only the best interests of the profession, that is, the optimum conditions for that practice of medicine which will be most favorable for both patient and physician. Secondly, each individual needs to reflect whether he has not been too tenacious of his own views even though they seemed thoroughly disinterested. What is essential at this time is unity, peace, and concord. All other considerations must yield. Compromise is often a word of unpleasant connotations, but honorable compromise is not only possible but at times a matter of the most urgent duty.

It is out of place here to suggest ways in which this unity can be accomplished and furthermore there is no need to do so. Surely the intelligent members of the State Society are not at a loss to devise means whereby to bring this about. In another farewell address Olser said "I have made mistakes but they have been mistakes of the head not of the heart." I am convinced that the heart of the profession in the state is not at fault. There is no group of professional men in the world more genuinely sincere than is the medical profession. Some factors have been at work which have distorted the thinking of too many. Therefore, an objective scrutiny of each one's thinking is most imperative. It would be offensive to suggest motives, but one fact is clear—unity, peace, and concord have not been in the forefront of the thoughts of a sufficient number.

A. F. Berens, S. J.

WISCONSIN LEADS COUNTRY IN REPORTING CASES OF TUBERCULOSIS

In proportion to the number of tuberculosis deaths in Wisconsin (719 in 1944) our state has reported more cases of tuberculosis than any other state. This position in case reporting has been held by Wisconsin during the last three years and we feel is in part a reflection of the case-finding activities by family physicians and by public health agencies. More cases of tuberculosis have been uncovered among apparently healthy people during these years than ever before. Both in case finding and case reporting this accomplishment shows splendid cooperation between physicians and the Wisconsin State Board of Health.

In spite of this splendid record, many cases of tuberculosis remain unreported. There are probably as many unknown tuberculous individuals in Wisconsin as there are known cases. Patients not reported, undiagnosed cases, and unisolated known sputum positive cases are still a problem to physicians and health authorities. While we have more tuberculous individuals ferreted out of our population than ever before, sanatorium admissions of minimal cases have declined in the last few years in Wisconsin sanatoria. This situation should be reversed. The sanatorium should be made the first resort of the tuberculous—not the last. Only through early discovery, prompt reporting, adequate isolation, and continued education can we hope to make our tuberculosis situation better.

Cases that are diagnosed must be reported for the protection of other persons. Tuberculosis should be thought of as an epidemic family disease, even if the spread to other members in the family may vary from a few months to many years.

Because tuberculosis is a communicable disease, Wisconsin laws require "reporting cases" in writing to the local board of health within a week after being diagnosed. The report must include the name, age, sex, occupation, and latest address of every person found with this disease.

Physicians have the opportunity for some real detective work in the families coming under their observation for various conditions. Ferreting out possible or suspicious tuberculous individuals in a family or even in a community can be as interesting and as satisfying an undertaking as the physician ever will have the opportunity of experiencing. Following the suspicious cases through further study to a definite diagnosis is again an interesting and challenging adventure.

We believe that by early discovery of tuberculosis before clinical symptoms occur, by prompt reporting, by adequate isolation and treatment, and by supervised rehabilitation—the physican still can contribute a large part to the complete eradication of this disease in Wisconsin.—A. A. P.

CAUSE AND EFFECT

As the 1945-46 editor of proposed compulsory health insurance is revealed to the American public with fanfare and salesmanship, one is moved to a reflective mood.

It is nothing new to call attention to the fact that it is as important, or possibly even more important, to determine *why* people get sick as to take care of them once they stray from the path of good health. Physicians have repeatedly emphasized that such factors in American life as the absence of milk from the diet of children, contaminated drinking water, and prosaic things as the presence or absence of sanitary facilities in dwellings are matters which should command the interest of Messrs. Wagner, Pepper, Murray, and Dingell.

We in Wisconsin generally regard ourselves far above the standards of many other states, but it might be well to recall some rather startling statistics compiled in the 1940 census of U.S. housing. For the entire United States, out of 37 million dwelling units over 11 million are without running water; over 15 million lack private flush toilets; and nearly 17 million are without private baths. In Wisconsin 51.3 per cent of the 897,719 dwelling units are without private bath; nearly 10 per cent are without running water or inside toilet; over 65,000 are one or two room dwellings; nearly 2,000 have no cooking facilities of any kind; 137,509 are lighted by kerosene or gasoline lamps; and 353,809 have no central heating. The unvarnished statistics reveal that out of 2,270 homes of non-whites in Wisconsin, one-third are valued at less than $300 per unit; and of 428,377 homes occupied by white persons, more than 70,000 have a value of less than $1,000 per unit.

Without a continued recital of statistics on eating habits of Wisconsin citizens and their adequacy of clothing, it stands to reason that persons who are living in crowded, unsanitary, and inadequately heated homes offer fertile soil for contagion and poor personal health.

While Washington social planners are busily engaged in suggesting compulsory health programs involving astronomical expenditures of taxpayers' funds, it might not be amiss to ask, in passing: "Why not treat the cause?"

RESEARCH IN CLINICAL PRACTICE

On other occasions the *Journal* has emphasized the point that investigational studies conducted through county medical societies could be of great aid to the entire profession. The work of physicians in Rock County was cited as a case in point.[1]

Now a member of the State Medical Society, Wallace Marshall, M.D., writing in the Quarterly Bulletin of Northwestern University Medical School[2]

[1] The Wisconsin Medical Journal (May, 1945) page 529, "An Opportunity for Greater Service."

[2] Chicago, 1945, Vol. 19, No. 3, page 240, Fall Quarter.

emphasizes the need for the training of the medical student in the work of scientific investigations. Doctor Marshall argues that many competent clinicians "find themselves unable to tackle a research problem and are unable to arrive at a logical conclusion even after completing an adequately controlled study on a subject which might prove of vital interest to others."

"The many doctors in the smaller communities are continually doing medical and surgical research, ' continues Doctor Marshall, "and they have to, because exigencies beyond their control arise at all times of the day and night, and they may not find the answer in any textbook or system of medicine. They must improvise continually."

The *Journal* is impressed with Doctor Marshall's point that there is a necessity for further methods of assisting those doctors who wish to do research. He offers as one suggestion that states develop a medical library service which in Wisconsin has long been conducted through the cooperative effort of the Society and medical school authorities.

In addition, it is suggested that medical journals provide an advisory board to assist prospective authors, and that each medical school establish either a compulsory or voluntary course on research proposals. A research club within the state society is also proposed as a means of interesting members and encouraging the interchange of ideas. Anticipating some form of government research aid, it is suggested that the research club would be in a favorable position not only to plan the utilization of these funds, but to inform the profession throughout the state on progress of research activities.

These suggestions are worthy of consideration. The real strength of the medical profession in this country has been its interest in scientific medicine. Let nothing divert it from the continued furtherance of its objective and its achievements and service to the advancement of public health.

YOU CAN'T CAN THE DOCTOR

Postwar reconversion plans of industry at times have a Buck Rogers air. The *Journal* notes with interest that a prominent manufacturing company suggests the "canning" in aluminum of valuable war surplus materials, running all the way from heavy machine tools to delicate instruments and electrical apparatus.

The idea of breaking out a new lot of jeeps with a can opener has a certain amount of appeal, but it would appear on the surface that those planning to conserve the creative talents of 1945 science do so on the assumption that progress has stopped and 1945 models of bazookas, gas masks, and radar equipment will meet the needs of 1966 when the few remaining remnants of the human race zealously get down to the task of determining which individual should hold the doleful distinction of becoming top man in the International Last Man's Club.

As one contemplates the possibilities of "canning" our prize examples of destruction for the edification, and more likely amusement, of our grandchildren, it seems to us that a certain segment of our Washington social planners have an idea that the medical profession can be hermetically sealed and put aside for use when and if some omnipotent soul in the shadow of the Washington monument decides the pattern of medical care for those living in a supposedly democratic society.

Medicine, more than most sciences, soon stagnates when divorced from a degree of social competition which in turn stimulates inquiry and quest for knowledge of the unknown. Shut medicine up in a vacuum of governmental bureaucracy, and the main spark which has made American medicine a leader in research will have been successfully extinguished.

Maybe science will be able to can the material products of American creativeness, but you can't can the doctor!

MEDICAL INSURANCE AND THE SPECIALTIES

No social effort is without an economic effect, and in the field of some, not without a direct impact upon the future of professional attainments and educational trends. A considerable part of the criticism leveled at compulsory health insurance arises from the inevitable fact that payment for the services of specialists will become fixed regardless of the income of the patient. Thus, it is argued that the government will have, perhaps unwittingly, developed another type of ceiling prices and grade labeling.

A similar criticism is sometimes offered of the voluntary plan—*except* that the ceiling applies only as to a given income level, and a level that is commonly accepted as one deserving of this special consideration. There is no grade labeling when there is but a qualified ceiling.

Dr. Henry C. Barkhorn writing in the Journal of the Medical Society of New Jersey* sums it up most aptly when he says: "Our services as specialists are necessary in maintaining high standards of medical care rendered through these plans, yet it is not actuarially possible at this time for plans operating on an insurance basis to pay a specialist a larger fee than that payable to a general practitioner for a specific service.

"This effort to protect the future welfare of medicine as a private enterprise means as much, and perhaps more, to the specialist group than to the general practitioner . . . as these plans gain experience they will be better adjusted to our needs than will any government controlled program."

* The Journal of the Medical Society of New Jersey, November, 1945, page 347.

Physicians in Service

For many months material in this section was carried under the title of "The Nation at War." With physicians still entering service, with many returning to reestablish themselves in civilian practice, and with many planning to continue in service for an indefinite time, it is the decision of the *Journal* to continue the section under a more timely title.

Military Notes

C. W. STOOPS, JR.

Lieutenant Charles W. Stoops, Jr., a regimental surgeon with the First Marine Division overseas for more than two years, was in Madison on leave during December. Lieutenant Stoops, a graduate of the University of Wisconsin Medical School, went on active duty with the Navy in July, 1943. He went overseas on November 8, 1943.

Lieutenant Stoops wears battle stars for service at New Guinea, Cape Gloucester, Peleliu, and Okinawa; he served at Tientsin, China, with the marine occupation forces, after V-J Day.

Lieutenant Stoops reported for further duty at Great Lakes, Illinois, on January 9.

Lieutenant Cyril J. Radl, former Wisconsin Dells physician, has been designated a Naval Flight Surgeon. He is stationed at the United States Fleet Air Reclassification Center, Naval Air Station, San Diego, California.

Lieutenant Radl entered the Navy January 7, 1944.

N. E. BEAR

Dr. Nathan E. Bear, Monroe physician, has been promoted to the rank of captain in the Navy. He is now on terminal leave after three years and eight months of service. Captain Bear has also been awarded the Bronze Star for action aboard the USS Nevada, on which he was serving as Senior Medical Officer when it was hit by a Kamikaze plane during the Okinawa campaign.

Lieutenant Gordon E. Carroll, Janesville, arrived home Tuesday, December 18, on leave. He has been serving with the Navy in the Pacific area for the past twenty-four months on the Ajax, a repair ship.

Doctor Carroll reported for duty May 3, 1943. He previously practiced at Laona for five years.

R. T. McCARTY

Dr. Robert T. McCarty, Appleton, now stationed at Great Lakes, has been promoted to the rank of commander. In service for three and one-half years, Commander McCarty spent twenty-five months in the South Pacific aboard the USS Tryon, hospital troop transport ship.

Commander McCarty practiced in Appleton for ten years before entering service.

E. M. DRURY

Captain Ernest M. Drury, New Richmond doctor, is expected home soon. He is now serving in the Medical Corps of the Army Air Forces, stationed in Texas.

Captain Drury entered the Army September 18, 1942.

Commander Adolph M. Hutter, Fond du Lac physician, writes that since January 1 he has been on duty at the United States Naval Hospital, Great Lakes, assigned as Chief of Sick Officers' Quarters. He was formerly at the United States Naval Receiving Hospital at San Francisco.

Doctor Hutter expects to be discharged April 1, under the present point system. He received his promotion to commander on November 1, 1945.

HAROLD W. KISHPAUGH

Lieutenant Commander Harold W. Kishpaugh, former Beloit physician and surgeon, arrived home on December 23, to spend Christmas with his family.

A veteran of nineteen months in the Pacific, Doctor Kishpaugh docked at Seattle, Washington, travelling from China. His ship helped land the first occupation troops in northern Japan shortly after V-J Day.

Commander Kishpaugh was commissioned in the Naval Reserve and reported for active duty January 10, 1944. He has been detached from his ship and reported to Great Lakes, Illinois, for further orders January 10.

Dr. Rolf A. Quisling, Madison, has been promoted to lieutenant commander in the Navy. Doctor Quisling is head of the eye, ear, nose, and throat department at the United States Naval Hospital, Mare Island, California.

Lieutenant Commander Quisling reported for duty November 8, 1943.

J. L. DEAN

Lieutenant James L. Dean spent a fifteen-day leave in Madison early in December. Lieutenant Dean was graduated from the University of Wisconsin Medical School in 1943. He attended the United States Naval Academy at Annapolis, and served at sea aboard the USS Rooks for fifteen months.

At the end of his leave, Lieutenant Dean reported to Great Lakes, Illinois, for further orders.

Returning Veterans

J. W. LAMBERT

After an absence of over three years, **Major Joseph W. Lambert** is resuming his medical practice in Antigo. He went into service October 26, 1942, and spent over a year overseas.

Doctor Lambert served in the Pacific area as medical officer in charge of the USS Tabinta and the USS Howell Lykes, both hospital and transport ships. His work also included establishing field hospitals and dressing stations in most of the Pacific area of operations, including the Philippine and Okinawa invasions.

Since the Japanese surrender Major Lambert has been engaged in hospital transport service to San Francisco from the Pacific area. He was in charge of the hospital at Naha during the destructive typhoon on Okinawa, and was promoted to major and cited for extraordinary services and devotion to duty.

Dr. Everett W. Reinardy has returned to practice in Janesville after four and one-half years of service with the Army Medical Corps. He served for two years in the United States, then went to Africa, Italy, and France, doing pathology work with the Fourth Medical Laboratory.

Dr. Maurice E. Monroe will soon resume his practice in Hartford. He was discharged from the Navy the first of the year, after having served for three years.

Dr. Henry V. Malin of Chicago, recently returned from the Army Medical Corps, has begun practicing in association with **Dr. E. T. Ridgway** of Elkhorn. Doctor Malin was with the Whitehall Clinic for seven years before entering the Army. He was recently discharged after serving for eighteen months in the European Theater of Operations.

ROBERT G. MAYER

Captain Robert G. Mayer, Kaukauna physician, was discharged from the Army Medical Corps in January. He went on active duty in August, 1942, and served with the 99th Evacuation Hospital.

Released from active duty with the Navy on January 11, **Dr. Gwilym Davies** has returned to Waukesha. He went on active duty in August, 1943. Doctor Davies was promoted to commander November 8, 1945. His terminal leave ends March 2, 1946.

Lieutenant Colonel Robert S. Baldwin has returned to the Marshfield Clinic. Doctor Baldwin entered the Army Medical Corps November 5, 1940, and was discharged November 23, 1945.

Dr. Milton J. Donkle, former Oshkosh physician, is to be associated in practice with **Dr. R. C. Hartman**, Janesville. Doctor Donkle entered the Army Medical Corps August 4, 1942, and served at Guadalcanal and other South Pacific posts.

Before entering the service, Doctor Donkle practiced general medicine, surgery, and pathology at Oshkosh for seven years.

C. L. QUALLS

Captain C. L. Qualls, former Juneau physician, has resumed his practice; he is now associated with Doctor Costello in Beaver Dam.

Doctor Qualls entered the Army October 21, 1942, and served in the European Threater of Operations. He was discharged December 9, 1945.

Doctor Raymond B. Dryer has resumed his practice in Poynette. He has been serving with the Navy since December 12, 1942. In March of 1943 he went to the South Pacific and spent one year in New Zealand and the New Hebrides. After his return to the states, Doctor Dryer was stationed in Philadelphia, at Great Lakes, and in Chattanooga, Tennessee after August, 1945. He was placed on inactive duty, and will be discharged at the end of his terminal leave, February 11, 1946.

Dr. Maurice G. Rice of Stevens Point was released from active duty with the Army Medical Corps January 8, 1946.

Captain Kilian H. Meyer, discharged from the Army Medical Corps, has taken up medical practice in Richland Center. Prior to his discharge, Doctor Meyer was Chief and Assistant Chief of General Surgical Service at Camp Carson, Colorado.

Captain Meyer entered service August 6, 1943, and was first assigned as commanding officer of the 291st Station Hospital in New Orleans. He later trained the 68th Portable Surgical Hospital at Camp Ellis and directed the Surgical Technicians' School there. He served five months overseas, first with the 92nd Engineers Regiment of the Fifth Army, and then as battalion surgeon and assistant regimental surgeon of the 86th Infantry Regiment of the 10th Mountain Division.

Doctor Meyer had a surgical residency at Columbia Hospital, Milwaukee, when he entered military service.

Lieutenant Commander Charles J. Brady, honorably discharged from the Navy, intends to resume his medical practice in Lake Geneva after taking a month's postgraduate work.

Commander Brady entered the Navy November 23, 1942, and served overseas for twenty-two months. He participated in the invasion of Guam on D-Day, and served in many places in the Pacific including the Philippines, Marianas, Admiralties, Saipan, Eniwetok, and Pelelieu. He holds the Asiatic, American theater, and Philippine Liberation ribbons.

Dr. David F. Cole resumed his practice in Ripon after serving with the Army Medical Corps since December 30, 1942.

Commander Lucian G. Culver, Eau Claire, is at home on terminal leave. He joined the Navy Medical Corps July 31, 1942, and spent the last eighteen months on the USS Ticonderoga, one of the largest aircraft carriers in the Navy, and on the USS Kenton, an assault transport. While serving on the Kenton he was in the Philippine and Okinawa campaigns, and the occupation of Japan.

Specializing in eye, ear, nose, and throat, Doctor Culver intends to resume practice with Drs. C. L. Larson and Merritt W. Wheeler in St. Paul, Minnesota.

Lieutenant Commander Horace S. Fuson, another Eau Claire doctor, is also at home awaiting his Navy discharge. He also went on active duty early in 1942, and served in naval hospitals for about a year before reporting for sea duty. Commander Fuson then served on the SS Typhoon and the MS Island Mail, both transports. He participated in the action in the Marshall, Marianna, Palau, and Philippine campaigns.

Doctor Fuson intends to resume his medical practice in Eau Claire soon.

J. C. DEAN

Lieutenant Commander Joseph C. Dean, discharged from the Navy on December 16, 1945, has resumed his practice in Madison. Commander Dean entered active service August 1, 1944.

Captain George O. Dunker, Milwaukee eye, ear, nose, and throat specialist, has returned to resume his practice following discharge from the Army Medical Corps. Captain Dunker entered the Army August 25, 1942, and served with the 56th Station Hospital in French Morocco at Casa Blanca and in Cairo, Egypt.

Major James S. Feurig, discharged from the Army Medical Corps with three and one-half years of service as a flight surgeon, has opened offices in Green Bay, in association with **Dr. A. H. Brusky.**

Major Feurig received seven battle stars during service in the European, Pacific, and China-Burma-India Theaters. He was wounded in aerial combat over Sicily in May of 1943; early this year he led an escape from the Japanese after being taken a prisoner behind enemy lines in Burma.

For his service, Doctor Feurig received the Distinguished Service Cross, the Silver Star, the Distinguished Flying Cross with one cluster, the Legion of Merit, the Air Medal with seven clusters, the Soldier's Medal, the Bronze Star, the Purple Heart, and the distinguished unit citation with three clusters. Foreign decorations awarded him consist of the French founragère, received from General de Gaulle; the Croix de Guerre; and the Chinese Order of the Green Dragon.

W. C. FINN

Dr. Walton C. Finn, Fond du Lac, who has resumed his medical practice after being discharged from the Army Medical Corps, was recently awarded the Bronze Star Medal and citation, which read:

"For outstanding services from March 4, 1945, to June 5, 1945, as chief of surgical service of the 373d station hospital, Major W. C. Finn contributed largely to the excellent care and extremely low death rate of casualties received from the Iwo Jima and Okinawa campaigns. His untiring efforts and supervisory ability at a time when the hospital was undergoing construction and facilities were wholly inadequate to properly care for patients, was largely responsible for saving many lives.

"His outstanding qualities of leadership reflected on the high morale and increasing efficiency of those under his jurisdiction. His initiative, professional knowledge, and skill made him of inestimable value to the hospital staff."

Doctor Finn entered the Army March 2, 1942, and served at Sheppard Field, Texas, before going overseas in October, 1944. He was stationed on Guam where he and his staff treated casualties from Iwo Jima and Okinawa. Personnel from two B-29 bases were also treated there.

Doctor Finn's terminal leave ended February 3, 1946.

Lieutenant Colonel Edgar S. Gordon, Madison, soon to report for his Army discharge, has served with the Medical Corps since October 9, 1942. Overseas twenty-six months, Doctor Gordon entered with the 44th Wisconsin Medical Regiment, and last March was transferred to the 116th Regiment at Leyte.

Upon discharge, Doctor Gordon will resume his duties with the Department of Medicine of the University of Wisconsin.

Major Erwin E. Grossmann, Milwaukee, has resumed his medical practice, limiting his work to ophthalmology. The effective date of his discharge from the Army is February 19, 1946.

While in the Army Medical Corps, Doctor Grossmann served as Chief of eye, ear, nose, and throat service at the Station Hospital, Camp Hulen, Texas, and at the Regional Hospital, Camp Maxey, Texas.

Before entering the service, Major Grossmann was a staff member of the Illinois Eye and Ear Infirmary, Chicago.

Captain John E. Martineau has reopened his office in Elkhart Lake, after being discharged from the Army Medical Corps. He entered the service July 9, 1942, and went overseas in September of that year.

Captain Martineau served for thirty-four months in the Hawaiian Islands, Canton, Leyte, and the Philippines. In October of 1944 he helped set up the Station Hospital on Leyte.

In June, 1945, Doctor Martineau returned to the United States and was stationed at Ashford General Hospital in West Virginia, and the Station Hospital at Erie Proving Ground.

Captain Martineau's terminal leave ends February 26, 1946.

Dr. Harmon H. Hull, former Brandon physician recently released from the Army, has opened medical offices in Waupun. Major Hull entered the service August 12, 1942, and will be officially discharged February 3, 1946.

H. G. MALLOW

Captain H. G. E. Mallow has resumed his practice in Watertown, following his recent discharge from the Army Medical Corps. Doctor Mallow served overseas for twenty-two months as a flight surgeon; he spent eighteen months in China. He entered active service June 3, 1943, and was discharged January 19, 1946.

Doctor Mallow was a resident surgeon in Milwaukee City Hospital for five years before entering service.

H. H. HEIDEN

The first Sheboygan physician to report for active duty with the Army Medical Corps in World War II, **Lieutenant Colonel Harry H. Heiden** has rejoined the Sheboygan Clinic staff after more than five years in service.

In October of 1940 Colonel Heiden went with the 127th Infantry to Camp Beauregard, Louisiana, for training as part of the 32nd Division. In April, 1941, he completed a refresher course in the Medical Field Service School, Carlisle, Pennsylvania. After further duty with the 32nd Division at Camp Livingston, Louisiana, Colonel Heiden was sent to Fort Hamilton, New York, to organize a medical detachment to become a part of an embarkation unit for overseas duty. They sailed from San Francisco on April 22 for Australia. Upon arrival, the unit was broken up and reassigned; Colonel Heiden took command of the 12th Station Hospital, Brisbane. The hospital was established at Townsville, and later provided medical care for the casualties of the Burma campaign.

In August, 1943, the doctor was assigned to move the 2nd Station Hospital from northern Australia to New Guinea. It was later moved to Markham valley, 40 miles from Lae.

In September, 1944, Colonel Heiden was returned to the states and assigned as medical member on a rating board in the regional office of the Veterans Administration facility in New Orleans, Louisiana.

Doctor Heiden was relieved from active duty November 14, 1945, at the Camp Chaffee, Arkansas, separation center.

Returned to Stevens Point after serving with the Navy since November, 1942, **Commander Herbert P. Benn** has resumed the practice of medicine with **Dr. Wayne F. Cowan.** Commander Benn entered the Navy as a lieutenant commander and first stationed at the Naval Air Station, Alameda, California. In July, 1943, he went to the school of aviation medicine at Pensacola, Florida, and became a qualified flight surgeon. In October of that year he was assigned to the USS Kasaan Bay, aircraft carrier, and served as the senior medical officer. The ship was assigned to anti-submarine patrol duty in the Atlantic until June, 1944, after which she served in the Mediterranean during the invasion of southern France. Pacific submarine duty followed.

Doctor Benn was promoted to commander in July, 1945, and was relieved of duty on the carrier just before the ship joined the invasion of Okinawa.

For the past six months, Commander Benn has served as obstetrician at Family Hospital, San Diego Naval Air Station, California.

Major Raymond H. Ludden has returned to his medical practice in Viroqua after serving as a surgeon for thirty-four months in the South Pacific. He participated in beachhead landings at Hollandia, Biak, Zahmboanga, and Jolo, and received the Bronze Star for "meritorious achievement in connection with operating a 100-bed hospital at Jolo for civilians."

Major Ludden spent three weeks with the occupational forces in Japan.

Doctor Ludden entered the Army Medical Corps September 12, 1942, and served at Camp Carson, Colorado Springs, Colorado, before going overseas.

Captain Elmer J. Shabart, Milwaukee physician, has returned after five years in the Army Medical Corps. Captain Shabart entered the Army in December, 1940, and was taken prisoner by the Japanese on Bataan April 16, 1942, while serving with the 12th Medical Regiment, Philippine Scouts.

On October 7, 1942, he was sent to Mukden, Manchuria; there he served as Chief Surgeon in the Hoten Prisoner of War Camp. The prisoners were liberated by the Russians August 17, 1945.

Doctor Shabart returned to the United States November 1, 1945, and is on terminal leave awaiting discharge.

Captain Herman L. Shapiro has reopened his offices in Prairie du Chien after two and one-half years with the Army Medical Corps. Doctor Shapiro was with the engineer group that took the Remagen bridge from the Germans.

Doctor Shapiro entered the Army August 28, 1943, and was recently discharged.

J. W. McROBERTS

Lieutenant Colonel Jerry W. McRoberts, on terminal leave from the Army Medical Corps, resumed his surgical practice as a member of the Sheboygan Clinic staff in December.

With his recent discharge from the Army at Fort Sheridan, Colonel McRoberts completed three years of active service with the Medical Corps, more than two years of which were spent overseas. He enlisted in December of 1942 and trained at Fort Custer, Michigan; he was then transferred to Fort Sill, Oklahoma, where the 44th General Hospital Unit trained and organized.

Doctor McRoberts was in the first group to leave for Queensland, Australia, in the fall of 1943. The unit was active in Australia for one year before being moved into the combat zone. On Leyte the doctor served as chief of the unit's surgical department. He returned to the United States in November.

Captain **John T. Sprague**, on terminal leave from the Army Medical Corps, has resumed his practice of medicine and surgery in Madison. He is associated with his cousin, **Dr. Lindley V. Sprague.**

Captain Sprague entered the Army December 21, 1942, and served in the European Theater of Operations for a year. He was in Germany for eight months, heading a surgical team assigned to the 119th Evacuation Hospital with the Ninth Army. Captain Sprague was awarded two battle stars for the Rhine crossing and the central Germany campaign.

Captain Sprague returned to the states in August, 1945, and was assigned to the surgical staff of the Regional Hospital, Camp Swift, Texas. He will be officially discharged February 17, 1946.

Lieutenant Howard F. Pagel, who left Ladysmith to enter the Army Medical Corps March 17, 1941, has reopened his offices and resumed his medical practice.

Doctor Pagel served in combat areas of the South Pacific; he has been serving in this country since his return about a year ago.

O. W. SAUNDERS

Major Otis W. Saunders, Green Bay physician and former health officer, was released from active duty with the Army Medical Corps and flown back to the United States in November, a month ahead of his expectations. Upon arrival home he wrote, "During the past three years I have enjoyed your letters and the issues of the Journal wherever and whenever they arrived. . . On 2 November I left Tokyo by plane and arrived in the United States on 4 November. Before leaving, I inactivated the 29th Portable Surgical Hospital located at Yokata Air Base, fifteen miles from Tokyo. My promotion to Commanding Officer and major, following the return of the commanding officer to the United States, gave me the task of taking the unit into Japan by air."

Major Saunders, who served in World War I, entered active service in World War II August 13, 1942, and spent most of his first year in the desert training center in southern California. He went overseas in August of 1943 with the 54th Evacuation Hospital, to Buna, New Guinea. After a month of detached service with the 4th Portable Surgical Hospital at Nadzab, he rejoined the 54th at Finchhafen. There the Arawae casualties were brought from New Britain for care; a large number of Australian and Navy personnel were included, as well as the Army patients, and the number of patients at one time reached 750.

After April 1, 1944, the doctor served with the 29th Portable Surgical Hospital. This highly specialized, mobile hospital was designed to be transported by plane or boat to points with no available facilities; thus the unit had to be prepared to handle any kind of major surgery or x-ray work. The unit served at Cape Gloucester, Aitape and Wakde, Leyte Gulf, and Guam. In June they went to Okinawa, and left for Japan in October.

Doctor Saunders will resume his practice in Green Bay, limited to general surgery.

Commander James W. MacGregor, former Portage surgeon, returned to civilian life in December after almost three years of service in the Navy Medical Corps.

Commander MacGregor entered the Navy January 18, 1943, and served as Medical Officer and Chief Gastro-enterologist in San Diego for over two years. He was then assigned to the United States Naval Base Hospital Number 18 on Guam as Medical Officer in Orthopedic Surgery.

Commander David C. Atwood, Madison, has returned to practice after serving with the Navy for over three and one-half years. Entering the service May 15, 1942, Doctor Atwood went to Pearl Harbor and remained there from June to November. He then served on the USS Thorton, seaplane tender, until July, 1943.

After serving at Base Hospital Number 2 on Efate, New Hebrides, until March, 1944, Commander Atwood proceeded to New Caledonia.

He returned to the states in May, 1944, and was assigned to the Bureau of Medicine and Surgery in Washington, D. C. After two months there, he was sent to the Receiving Station Dispensary at the Washington Navy Yard.

In November, 1945, Doctor Atwood was promoted to commander. He was released from active duty November 15, and is on terminal leave until February 16, 1946.

R. J. WINKLER

Lieutenant Colonel Raymond J. Winkler of Hilbert, now at home, was among those awarded the Croix de Guerre by General de Gaulle. Colonel Winkler, commander of the 75th Medical Battalion Armored, entered the Army March 9, 1941, and served at various posts in this country before going overseas in February of 1944.

W. C. SHEEHAN

Commander W. C. Sheehan, in the Navy and Marine Corps since May 4, 1942, was discharged January 13, 1946 and has resumed his medical practice in Stevens Point.

Entering the Navy as a lieutenant, the doctor was first stationed at the Naval Training Station at San Diego, California. He next served as assistant surgeon at the Naval Receiving Station, San Pedro. In April of 1943 he was assigned to the Fleet Marine Force at Camp Elliott, as senior medical officer of the 18th Replacement Battalion. In June Doctor Sheehan went overseas and served with the 3rd Marine Amphibious Corps, participating in landings and the occupation of Bougainville.

In May, 1944, while stationed at Guadalcanal, he was promoted to lieutenant commander. In August Commander Sheehan participated in landings and the occupation of Guam. During the occupation of Bougainville and Guam the doctor served as battalion surgeon of the Marine 155 mm. gun battalion.

Returning to the United States December 23, 1944 Doctor Sheehan was reassigned to the Navy, and has served as senior medical officer in charge of the outgoing unit dispensary at Great Lakes since January, 1945. He was promoted to commander November 5, 1945.

Captain Paul S. Herzog has resumed his practice of medicine and surgery in Kenosha after two and one-half years with the Army Medical Corps. He entered service May 6, 1943, and went overseas October 30, 1944. He served with the 198th General Hospital in England and later in Paris, working in the communicable disease unit.

Doctor Herzog later supervised captured German military hospitals in Germany. He was discharged November 9, 1945.

F. H. ZIMMERMAN

Commander Felix H. Zimmermann of Watertown is reestablishing his medical practice after over two years' service with the Navy. He recently received his promotion to commander while on duty in the Philippines.

Doctor Zimmermann entered service October 4, 1943, and will receive his discharge March 7, 1946.

Dr. Robert M. Moore has been with the Frederic Clinic since December 3, following his discharge from the Army Medical Corps. He entered the Army in August, 1942, and served as a Flight Surgeon with the Army Air Forces. He was overseas for seventeen months, and his service including caring for B-29 bomber crews on Saipan. He was released from active service October 16, and discharged December 25, 1945.

The following doctors have returned to Oshkosh following their discharges from service: Drs. **R. H. Bitter, E. B. Williams, M. C. Haines,** and **C. H. Behnke.** Doctor Bitter entered the service March 5, 1941, and will be officially discharged February 13, 1946. Doctor Williams entered October 5, 1942. Doctor Haines entered September 15, 1942, and was discharged December 12, 1945.

J. L. MOFFETT

After four years of military service, **Major James L. Moffett** has returned to Platteville where he will resume his practice as a physician and surgeon. Major Moffett entered service in October, 1941, and spent two and one-half years overseas. He will be discharged February 26, 1946.

Dr. Carl Milchen, Boscobel, who received his discharge from the Army Medical Corps November 14, was awarded the Bronze Star "for meritorious achievement in connection with military operations against the enemy at Leyte Province and Luzon Island, Philippine Islands, from October 20, 1944, to May 21, 1945."

Doctor Milchen entered the service August 17, 1942.

RECENT PROMOTIONS

Dr. Nathan E. Bear, Monroe, to captain (USNR)
Dr. Gyilym Davies, Waukesha, to commander
Dr. Milton S. Freedman, Milwaukee, to captain
Dr. Adolph M. Hutter, Fond du Lac to commander
Dr. Robert T. McCarty, Appleton, to commander
Dr. Rolf A. Quisling, Madison, to lieutenant commander
Dr. Otis W. Saunders, Green Bay, to major
Dr. Felix H. Zimmermann, Watertown, to commander

VETERAN PHYSICIANS' EXCHANGE

This page will be devoted to a classified section, open without charge to: (a) veteran members desiring location and (b) other members having professional openings suitable for men returning from military service.

LOCATIONS WANTED

LOCATION WANTED: Young orthopedist, completely trained in both reconstructive and traumatic surgery, desires industrial or group practice connection in or near Milwaukee. Available after July 1, 1946. References exchanged on request. Address No. 100 in care of the Journal.

LOCATION WANTED: 39 year old physician with 3-year residency in General, Gyn., and Traumatic Surgery, 4½ years general practice, and 4½ years in Army hospitals, desires location in a northern or central state community of 2,000 to 25,000, with hospital facilities. Would consider association with established practitioner. Available immediately. Address No. 101 in care of the Journal.

WANTED: Location or association with physician in S. W. United States. Age 39 years. Class A graduate. Ten years active civilian and military experience, including surgery. Address No. 102 in care of the Journal.

LOCATION WANTED: General practitioner, 36, will purchase practice, home, etc.; available May 1, 1946. Can arrange personal interview immediately. Address No. 103 in care of the Journal.

ASSISTANCE WANTED

PHYSICIAN WANTED: Village of 1,200. Fourteen miles to three hospitals. No competition. Farming community. Office space available. Address No. 108 in care of the Journal.

VETERAN PHYSICIANS: This is a strategic time to enter public health. State Board of Health has 2 openings for physicians with executive ability as directors of the tuberculosis and venereal disease divisions. Salary $4,800 to $5,400 plus necessary traveling expenses, Madison headquarters. 5 district health officers also needed. If you were under 40 when entering the armed services and can otherwise qualify, write Dr. Carl N. Neupert, State Health Officer, Madison 2, Wisconsin.

WANTED: Man to take over my home in town of 500. All modern, cost $14,000; will sell for $6,000. Oil burner, 2-car garage, redecorated. Modern office with $2,000 improvements; 8 rooms. Office rent $30, ground floor. Doctor to run office, and work with a three-man clinic 7 miles away in town of 4,000 with modern hospital. Clinic to be formed and new building to be built soon. Address No. 104 in care of the Journal.

WANTED: Southern Wisconsin Clinic needs energetic M. D., general work, surgical, obstetrical, medical and industrial. Good opportunity for permanent position. Address No. 105 in care of the Journal.

PHYSICIAN WANTED: About March 1 to take over a well established practice in a prosperous lumbering and farming community. Fully equipped office with x-ray equipment and a heated residence furnished. No cash outlay required when starting. Address No. 106 in care of the Journal.

ASSISTANT WANTED: General practice, surgical training, with prospective partnership. Address No. 107 in care of the Journal.

WANTED: Assistant in a large general surgical and medical practice by physician in city of two thousand, having a 20-bed community hospital, in prosperous farming community in midwestern Wisconsin. Must be willing to do some surgery and obstetrics. Full partnership after one year, if conditions satisfactory. Salary determined by amount of experience. Fully equipped office including fluoroscope, x-ray, BMR, EKG, etc. Address No. 109 in care of the Journal.

FOR SALE: $28,000 property; four apartments besides own 5-room and 4-room offices. Garage in basement. Located on corner of 18th and Wells Streets in heart of Milwaukee medical center. Children's Hospital and Curative Workshop near; one block to Deaconess, three blocks to Marquette University, five blocks to Milwaukee Hospital, Mt. Sinai, etc. Ten blocks to heart of city. Could use dentist with myself or whoever buys the place, or splendid clinic location. Address No. 110 in care of the Journal.

HELP WANTED: State hospitals at Mendota and Winnebago and colonies and training schools at Chippewa Falls and Union Grove are in need of doctors, nurses, social workers, technicians, and other personnel. If interested contact the superintendents, or Dr. W. J. Urben, State Department of Public Welfare, 128 South, State Capitol, Madison.

For additional classified advertisements, see the Physicians' Exchange, page 274.

Recent Releases From Service*

Physician and Location	Date Discharged
Baldwin, R. S., Marshfield	November, 1945
Benn, H. P., Stevens Point	December, 1945
Birge, E. A., Madison	December, 1945
Bitter, R. H., Oshkosh	February, 1946
Buckley, R. A., Eau Claire	December, 1945
Cary, J. F., Sheboygan	October, 1945
Churchill, B. P., Milwaukee	July, 1945
Cogan, L. J., Milwaukee	February, 1946
Dean, J. C., Madison	December, 1945
Denys, K. J., Green Bay	January, 1946
Dricken, H. N., Milwaukee	September, 1945
Dryer, R. B., Poynette	February, 1946
Finn, W. C., Fond du Lac	February, 1946
Flannery, J. V., Wausau	January, 1946
Frank, H. A., Neillsville	December, 1945
Franklin, Emil, Milwaukee	July, 1945
Fuson, H. S., Eau Claire	November, 1945
Gale, J. W., Madison	November, 1945
Gollin, F. F., LaFarge	January, 1946
Grossmann, E. E., Milwaukee	February, 1946
Haines, M. C., Oshkosh	December, 1945
Hartman, A. S., Milwaukee	December, 1945
Hatleberg, E. J., Rice Lake	February, 1946
Hoyer, E. C., Beaver Dam	December, 1945
Hull, H. H., Brandon	February, 1946
Imp, J. F., Milwaukee	November, 1945
Joachim, F. G., Madison	January, 1946
Kidder, E. E., Stevens Point	October, 1945
Ludden, R. H., Viroqua	January, 1946
Ludwig, E. P., Wausau	January, 1946
Mallow, H. G., Watertown	January, 1946
Martineau, J. E., Elkhart Lake	February, 1946
McBain, L. B., Appleton	January, 1946
Meyer, K. H., Richland Center	February, 1946
Milchen, C. S., Boscobel	November, 1945
Moffett, J. L., Platteville	February, 1946
Moland, O. G., Augusta	December, 1945
Moore, R. M., Frederic	December, 1945
Moran, C. J., LaCrosse	February, 1946
Murphy, J. L., Park Falls	January, 1946
Pomainville, L. C., Wisconsin Rapids	January, 1946
Qualls, C. L., Beaver Dam	December, 1945
Quisling, G. D., Madison	January, 1946
Raine, Forrester, Milwaukee	February, 1946
Regner, M. F., Port Washington	February, 1946
Rosenberg, S. W., Milwaukee	November, 1945
Sargent, J. C., Milwaukee	February, 1946
Saunders, O. W., Green Bay	February, 1946
Schneider, C. S., Milwaukee	December, 1945
Schramel, A. J., Milwaukee	January, 1946
Schuler, W. H., Fennimore	February, 1946
Schwade, L. J., Milwaukee	November, 1945
Seifert, K. A., Milwaukee	December, 1945
Sheehan, W. C., Stevens Point	January, 1946
Shemanski, L. S., Menasha	January, 1946
Sprague, J. T., Madison	February, 1946
Sullivan, J. M., Milwaukee	January, 1946
Twohig, D. J., Jr., Fond du Lac	December, 1945
Vedder, C. A., Marshfield	December, 1945
Waffle, R. L., Fond du Lac	February, 1946

* Members of the State Society listed in boldface.

With so many physicians being released from active duty, the Journal has suspended publication of the APO and FPO monthly news letter

RECENT WISCONSIN LICENTIATES

The Wisconsin State Board of Medical Examiners, at a meeting held in Madison on October 10, licensed through reciprocity the following physicians in the practice of medicine after they had successfully passed an examination.

Name	*School of Graduation*	*Year*	*Address*
Callen, Irwin R.	Illinois	1926	8626 Ingleside Avenue, Chicago, Illinois
Erikson, Herbert B.	Chicago	1927	Chicago, Illinois
Ihle, Lyman Edward	Kentucky	1938	615 Dover Street, Chippewa Falls, Wisconsin
Kappus, Harold	Creighton	1940	604 Seventy-fifth Street, Kenosha, Wisconsin
Moore, George E.	Illinois	1939	2505 North Nevada, Colorado Springs, Colorado
Snodgrass, Herbert M.	Kentucky	1940	Pember Nuzum Clinic, Janesville, Wisconsin
Thelen, Christine (F)	Virginia	1937	2212 Rowley Avenue, Madison, Wisconsin

Occupational Tuberculosis*

By HARRY A. NELSON
Madison

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Mr. Nelson is director, Workmen's Compensation Division, Industrial Commission of the State of Wisconsin.

THE Wisconsin workmen's compensation act administered by the Industrial Commission provides compensation benefits, medical and monetary, for service-incurred injury to employes subject to the act. Injury is defined by the act as mental or physical harm caused by accident or disease arising out of employment. It will be noted that this language is broadly inclusive and provides benefits for every sort of mental or physical condition which may occur because of employment.

How does the law apply to tuberculosis?

If it can be shown that tuberculosis is caused or aggravated by reason of employment, necessary medical treatment is required to be provided. If disability results payment of monetary compensation becomes due. The disease may result because of contact with co-employes, or with other persons in the course of employment. Doctors, nurses, or attendants may come in contact with tuberculous patients in hospitals or sanatoria and thus contract the disease.

Compensation benefits are payable only to those whose status is that of employes subject to the compensation act. Many doctors and nurses are not employes. Those are doctors and nurses who practice their profession independently and are not engaged at regular salary and are not subject to direction and control. Physicians on salary, student nurses, and nurses and attendants regularly employed by hospitals or sanatoria are generally held to be employes.

To prove injury there must be causal connection shown as between service performed and disease acquired. It is not always easy to establish causation. Question frequently arises as to whether tuberculosis was contracted exogenously in the course of employment, or endogenously by lighting up of a latent infection merely by "spontaneous" activation or by an agency not connected with employment.

A fair number of claimants subject to the act have been able to establish that contact with patients resulted in tuberculous infection, either directly or by way of aggravation. In either case compensation benefits become due. Most of the compensated cases are those of nurses who have been in attendance on tuberculous patients.

Danger of Infection

The danger of infection is, in some respects, greater in general hospitals than in tuberculosis sanatoria. That is because of association of hospital employes with patients who have active tuberculosis which has not been discovered at the time of contact between employe and patient, and hence not guarded against by safety precautions as is more often done in tuberculosis sanatoria where the danger is patent and recognized. In view of this insidious and lurking danger, can any hospital be excused for not exercising the known and practical precautions which can be taken to reduce or eliminate danger of infection to its employes? The methods are well known and available to all hospitals and sanatoria. Yet, while the general fight against tuberculosis is waged with increasing zeal and volume, some of the very hospitals set up to cure the sick actually and avoidably assist in producing sickness. Astonishingly we have heard doctors and hospital authorities criticize nurses and doctors for claiming compensation for tuberculosis contracted in employment. This harks back to the laissez-faire days of common law at about the turn of the century where risks of employment were legally required to be assumed by employes. Compensation acts changed this theory radically and provided that employes were to be compensated for service-incurred injury and disease, and the cost was to be assumed initially by the employer, and by him in turn charged to the consumer of product or service. After more than thirty years of compensation administration, it is difficult to comprehend the assumption of the older attitude. And why nurses and doctors should be kept in the dark or misled as to the existence of the hazard is equally incomprehensible. It is now axiomatic in most states that all employes are entitled to be fully informed as to hazards of service, so that they may elect whether or not to continue in employment attended by such hazards and, if employed, to have those hazards reduced by the employer to a reasonably attainable minimum. Students, nurses, and doctors have a right to know the danger which they face; to have all known and practicable precautions invoked to combat the danger; and to have early care instituted when the danger has not been

* Revision of "Hazards of Tuberculosis in Industry," *The Crusader*, October, 1945.

avoided. They have a right to pre-employment and periodic physical examinations so that they may avoid exposure altogether when their condition so dictates. and so that they may not infect others if they themselves already have an active lesion. Early tuberculosis is usually without symptoms and requires careful examination for disclosure. Early treatment usually means cure. Late treatment holds out much less hope.

We have been told that if liability is to be found in cases of this type, it will be difficult to hire nurses and attendants, the implication being that deception is justified in order to be able to hire employes who might not be willing to assume the hazard if informed. The position is a startling one and sometimes taken not with malice, but because of wishful thinking that the hazard is really slight and the less said about it the better. The facts do not bear out this fallaciously hopeful position. It is highly encouraging to know that the hazard can be largely avoided or eliminated, and disease prevented by proper education and control measures.

In a study made by Doctor Oatway at the Wisconsin General Hospital in 1936, 1,500 general patients were studied who had no demonstrable symptoms of tuberculosis. Thirty-two of them were found to be tubercular. In consultations by him in 1940, 175 cases were found by the physician to have lung disease. Forty of these cases had infectious tuberculosis.

At Muridale Sanatorium in Milwaukee students from hospitals may take three months of tubercular service. In a study made, 80 per cent of them were found to have positive tuberculosis when admitted to the course following preliminary training in general hospitals. The normal for this age group is 25 per cent. At the end of the three months' period of service 60 per cent of the remaining 20 per cent became positive reactors. These figures eloquently speak for the hazard which attends service in general hospitals as well as in tuberculosis sanatoria.

Avoidance of Infection

Where safety precautions are observed, it is generally believed that much infection may be avoided. Hospitals and sanatoria have done much good work in the way of education of attendants and patients instructing them in the avoidance and control of coughing, contacts, disposal of excreta, use of masks, and the exercise of sanitary precautions. In 1939 the American Hospital Association, through its counsel on professional practice, issued a 78-page pamphlet on "The Management of Tuberculosis in General Hospitals." Can there be any excuse for an accredited hospital not following the program in the pamphlet issued by its own association?

A few cases have been allowed compensation where tuberculosis has followed traumatic injury to the chest or lungs, although these cases are comparatively rare. Claims have been made predicated on "lowered resistance" following injury but have usually been denied on the grounds that it is speculative to ascribe tuberculous disability to that cause. However, if causal connection can be shown liability will exist.

The largest number of tuberculosis cases which have come before the commission are those which have followed silicosis. It is well established that silicosis predisposes the patient to initial tuberculous infection or to lighting up of a latent infection, perhaps quiescent for years. When, therefore, a claimant can establish that he has silicosis in an appreciable degree, and that tuberculosis has been superimposed, he has made out a good case. Many workers have received awards for tuberculosis following exposure to siliceous dust in the foundries, quarries, and mines of this state. The hazard also exists in varying degrees in manufacturing plants which make use of silica in various forms in their processes. It is the general concensus that tuberculosis on a silicotic base is very difficult of cure as compared with cases not so based.

The benefits which are awarded under the compensation act are 70 per cent of the weekly wage, not to exceed compensation of $25.90 per week, and unlimited medical and hospital care necessary to make the patient comfortable and to restore him to health as far as that may be done.

The Industrial Commission recognizes that a far more important factor than compensation is the prevention of injury. The law provides that employers must supply their employes with safe places and safe methods of work, and that in order to effect this objective the commission may adopt standards which become law. The commission has adopted codes of saftey, among which are those providing for the elimination or disposal of dust containing silica, so that a damaging amount may not reach the lungs of employees. Penalties are provided for failure to follow these orders. Further provision calls for payment of 15 per cent increased compensation by the employer where injury resulted because of his failure to observe safety orders or to supply a safe place and safe methods of work. Employers in Wisconsin have been extremely cooperative in observing good housekeeping and following orders as to elimination of dust or substitution of methods obviating the silica hazard to a great degree.

As a result of educational methods, persuasion of law, and economic sanctions silicosis in Wisconsin has become largely a thing of the past and will continue to decrease in the future. This will result in prevention of many cases of tuberculosis which otherwise would have developed in the fertile field of the lung caused by massive exposure to silica. Safety and control measures with education of physicians, nurses, and attendants in hospitals and sanatoria should result in a decrease of cases caused by personal contact with patients. Will anyone agree that less should be done by agencies which are committed to cure and relieve illness and disease?

Industries more and more arrange for pre-employment and interim examinations of employes with a view to discovering conditions which make it dangerous for them to continue work or to work in certain employments. Frequently these employes can be placed in other employment which is suitable and safe for them. The test should be that of safety for the worker and those with whom he comes in contact. Because of these examinations tuberculosis is often detected sufficiently early so that treatment may be initiated. Especially in the case of those workers who are exposed to silica, frequent examinations will disclose an increasing degree of silicosis which may make the lung a probable medium for tuberculous infection. Such employes can be shifted to employment which will not expose them to the deleterious agent, or precautions can be taken which will insure that further exposure will be minimal and consequently harmless.

The practice of physical examinations of all employes cannot be too highly commended. Many cases of tuberculosis have been discovered in such examinations, making it possible to prevent infection of others and to cure the person whose infection has been disclosed.

Cancer Detection Centers

DURING this past year the Committee on Cancer of the State Medical Society has devoted considerable thought to the question of cancer detection centers. Aware of the fact that the American Cancer Society has encouraged the establishment of centers as a means of public education and as a method of detecting cancer in its early, curative, stage the committee has given thorough review of the subject as it relates to the profession of medicine in Wisconsin. Since the formulation of principles to guide those interested in the establishment of cancer detection centers in Wisconsin it is gratifying to note that actions of the Committee on Cancer of the State Medical Society of Wisconsin closely parallel action of the House of Delegates of the American Medical Association, December 5, 1945.*

The Committee on Cancer has been in uniform agreement that nothing can approach a thorough and intelligently given physical examination as the best method of detecting cancer in time to provide effective medical treatment. While individual examinations and *diagnosis* can and should be made by the family physician it appears to the committee that under certain circumstances the establishment of a carefully conducted detection center would serve to implement the preventive features of the cancer program and reveal many instances of carcinoma which might otherwise go undetected until too late for effective treatment.

In March, 1945, the Committee on Cancer expressed the viewpoint of its members that "The Committee on Cancer of the State Medical Society of Wisconsin recognizes the function and purpose of the cancer detection center as an effective means of public education, and leaves to the discretion of the component county medical societies the formation of such centers if and when local community needs dictate the wisdom of establishing such centers."

It was felt by the committee that it was not in a position to evaluate effectively community medical resources or localized demands for such services, but that it would assist county societies by establishing rules and procedures for the organization and operation of cancer detection centers, as well as establishing procedures clearly defining the relationship of the Field Army and the county society in relation to any program undertaken. The material which follows is distributed as a guide for physicians and lay persons interested in the cancer program in the state:

Relationship of the Field Army and County Societies in the Establishment of Cancer Detection Centers in the State of Wisconsin*

1. Any local unit of the Field Army, Wisconsin Division, may stimulate the formation of a cancer detection center by initially contacting the county medical society and volunteering the help of the Field Army in conducting the center according to rules set forth by the office of the State Commander, subject to approval of the Committee on Cancer of the State Medical Society.

2. The decision whether or not a cancer detection center shall be operated rests entirely within the province of the county medical society. If the county medical society expresses a desire to establish a detection center the county society shall determine where and when such center shall be conducted, and all matters concerning staff and procedure shall rest in the county medical society.

3. When a county medical society agrees to conduct a cancer detection center and the cooperative efforts of the Field Army are to be utilized a suitable resolution from the county medical society shall

* "The Council recommends that the House of Delegates approve the following standards . . . (a) Definition: A cancer detection, cancer prevention, well person clinic is designed to detect abnormalities not producing symptoms sufficient to send the patient to the doctor. These clinics do not diagnose or treat diseases: (b) no such clinics shall be established in any community without the approval of the county medical society"—J. A. M. A., page 1209, December 22, 1945. Recommendation approved.

* Passed by the Administrative Committee of the Committee on Cancer on July 30, 1945, and affirmed by the Committee on Cancer on November 24, 1945.

be filed in duplicate with the office of the State Commander of the Field Army, Wisconsin Division, and the State Commander in turn will file one copy of the resolution with the Committee on Cancer of the State Medical Society, through the office of the Secretary.

4. If Field Army funds are requested for support of the center an itemized budget shall be submitted at the time the resolution is presented, and such budget shall be approved by the Administrative Committee of the Committee on Cancer.

5. Upon receipt of a resolution from the county medical society indicating a desire to establish a detection center the Committee on Cancer, over the name of the chairman, shall address a communication to the county society expressing a desire to be of assistance and transmit to the county society a copy of the basic principles to be determined by the Administrative Committee as suggested guides for the establishment and conduct of cancer detection centers in Wisconsin.

As a means of assisting county societies interested in establishing cancer detection centers in the State of Wisconsin the Administrative Committee of the Committee on Cancer asked Dr. A. R. Curreri, Madison, to prepare material for consideration by the Committee on Cancer. The following material was first approved by the Administrative Committee, and given unanimous approval of the Committee on Cancer on November 24, 1945. The Council of the State Medical Society has likewise approved the principles of the cancer detection program, as directed through the Committee on Cancer.

Suggested Standards For the Organization and Operation of Cancer Detection Centers in the State of Wisconsin*

Purpose. Cancer Detection Centers are organized to provide facilities for the early recognition of cancer or suspected malignant lesions. These Detection Centers are neither diagnostic nor therapeutic centers. Furthermore, since the examinations are directed solely for the detection of malignant diseases, they do not constitute a health examination. All patients with definite or suspected lesion are to be referred to their own family physician for further diagnostic study and therapy.

Organization. The Detection Centers will be organized and will remain under the jurisdiction of the county medical society or joint county medical societies. The medical personnel, time, and site of these centers shall be determined either by the county medical society or its Committee on Cancer.

The state and local organizations of the Field Army of the American Cancer Society will aid the county medical society in every possible way by developing publicity and in the actual operation of the center.

Personnel. The personnel required for the operation of these Detection Centers will vary according to (1) size of community served, (2) number of available examiners, and (3) amount of examining equipment. Therefore, these centers shall be grouped as those with (1) minimal personnel, (2) advantageous number of personnel, or (3) advisable number of personnel.

1. Minimal Personnel.

a. Physicians—One physician who shall do the complete examination and evaluate the findings.

b. Nurses—One nurse who may take the medical history and aid the doctor in the examination.

c. Secretarial work—Members of the Field Army or other volunteers can here render valuable service by admitting patients, allaying fear present in many patients entering such a center, and executing the necessary secretarial work required both at the time of examination and in the follow-up.

2. Advisable Number of Personnel—In order to create interest for the layman and to expedite the examination, teams of physicians and nurses can be organized.

a. Physicians—Internist and surgeon to examine the patient. One of these doctors shall evaluate the findings.

b. Nurses—Two or more nurses to take histories and assist the doctors.

c. Secretarial assistants—Members of American Field Army or other volunteers as stated under Minimal Personnel.

3. Advantageous Number of Personnel—The best results will be obtained when a Detection Center not only contains the basic team of internist and surgeon but also includes the specialties.

a. Physicians—Internist, surgeon, and one or more of the following: Gynecologist, dermatologist, urologist, pathologist.

b. Nurses—Sufficient number for history taking and assisting the doctors.

c. Secretarial assistance—As stated above.

Remuneration. Inasmuch as the medical and secretarial staff perform their duties on a voluntary basis, they should not expect any financial remuneration. It would be most advantageous if nurses could contribute their time without financial compensation.

History and Physical Examination. At the time of admission a signed statement should be obtained from the patient permitting the Detection Center to give the medical findings to a physician selected by the patient.

The medical findings should be recorded on a form sheet. At this time we would like to express our appreciation for the cooperation and assistance of the Janesville Tumor Clinic in the development of medical and follow-up forms. (Forms A and B)

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* Prepared by the Administrative Committee of the Committee on Cancer of the State Medical Society and approved by action of the Committee on Cancer.

These suggested standards are submitted to county medical societies to assist with the establishment of Cancer Detection Centers in Wisconsin.

Special examinations, such as proctoscopies, gastroscopies, x-rays, should be included only if requested by the county medical society.

Following the examination a report of the findings is sent to the family physician together with a request regarding the ultimate disposition of the patient. (Form C) Facilities for filing of records and continuance of follow-ups should be set up.

Form A

CANCER DETECTION CENTER

(City) Wisconsin

Case No. _____

Source of Information in regard to Clinic _____

_____

Patient's Name _____

Spouse's Name _____

Address _____ Tel._____
City State

Physician's Name _____

Address _____

Occupations in Past 10 Years _____

_____

_____

_____

Age	Sex	Date Birth	SMWD	No. Child

Descent	Nativity	Yrs. in U. S.	Yrs. in Wis.

History—Cough, hemoptysis, pleuritic pain, expectoration (type and amount), difficulty in swallowing, early satiety, loss of weight, tarry stool, hematemesis, increasing constipation or diarrhea, blood in urine, vaginal discharge (watery, purulent, bloody), breast lumps or pain, fatigability, weakness, body ulcers or masses.

_____

Family History of Cancer—Whom, what organ—

_____

Examination of Skin, Head, Throat, and Neck—

_____

Breasts and Axillae—

_____

Chest and Abdomen—

_____

Pelvis—

_____

Genito-Urinary System—Including Prostate—

_____

Rectal—

_____

Other Systems—

_____

Impression and Recommendations—

Final form will include a Waiver of Privilege signed by the patient.

_____
Signature of Medical Evaluator

Form B

CANCER DETECTION CENTER

(City) Wisconsin

Miss
Mr.
Mrs. _____ who was given a preliminary examination at the Cancer Detection Center at_____

Hospital was found to have _____. He She has requested that the result of this examination be submitted to you. Will you kindly let us know on the enclosed blank whether or not this patient reported to you and what disposal was made of this case, in order that the records of this clinic may be complete and up to date at all times.
Kindly send report to:

Name _____

Address _____

Sincerely yours,

Form C

CANCER DETECTION CENTER

(City) Wisconsin

On _____ Mr. Mrs. Miss _____
(date)
On account of _____
was referred to you for further examination and treatment, if required. In order to complete the files of the Cancer Detection Center, will you kindly give the following information:
Type of further examination completed _____

_____

_____
X-ray, Cystoscopic, Biopsy, etc.

Result of above examination _____

_____

_____

What treatment, if any, was instituted _____

_____

_____
X-ray, Operation, other

Results _____

Kindly send report to _____

Sincerely yours,

News Items and Personals

Funds Raised For Doctor's Children

The heroism of *Lieutenant Commander George William Fox*, 28, of Racine, inspired his fellow physicians to contribute $6,000 for the future of his children. Commander Fox died in action aboard the Aircraft Carrier Franklin after it was bombed by the Japanese near Kobe on March 19, 1945. He was awarded the Navy Cross posthumously for extraordinary heroism under fire.

The money, still being contributed by fellow physicians and staff members of the Milwaukee Hospital, is to be set up in a trust fund to assure a college education for Doctor Fox' three children. The fund was started by a former associate, *Dr. O. R. Lillie* of Milwaukee.

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Dr. Charles R. Brillman has opened offices in the Valuch building, Cudahy. A graduate of the University of Wisconsin, Doctor Brillman is an eye specialist.

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Dr. Rex E. Graber, practicing physician and surgeon at Stanley for fifteen years, opened offices in Chippewa Falls recently. A 1923 graduate of Rush Medical College, Doctor Graber practiced in Bismarck, North Dakota, for six years following his internship at Kings County Hospital, Brooklyn, New York, before going to Stanley.

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Research Group Formed By Marshfield Doctors

Eight Marshfield doctors have filed incorporation papers with the Secretary of State for the Marshfield Research Foundation for Medicine and Allergy, a non-profit organization to promote research and education in the fields of medicine and allergies.

The incorporators are: *Drs. Robert S. Baldwin, Frank A. Boeckman, Lyman A. Copps, Karl H. Doege, Stephan Epstein, George L. McCormick, Allen L. Millard,* and *Roy P. Potter.*

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Two doctors, formerly associated in practice in Eau Claire, are now engaged in practice in their respective fields on the west coast.

Dr. Martha Kohl has been on the staff of the Orthopedic Hospital for Crippled Children in Los Angeles for the past year as chief of the anesthesia staff. She is also a member of the staff of St. Luke's Hospital in Pasadena.

Dr. Lois G. Cobb is the psychiatrist at Las Encinas Sanatorium in Pasadena; it is nationally known because of prominent people who go there for rest periods.

Doctors Kohl and Cobb went to Los Angeles County from Eau Claire in July of 1944. They were members of the State Medical Society.

Dr. V. E. Ekblad, Superior, was elected president of the St. Joseph's Hospital medical staff at the annual meeting Thursday, November 15. He took office January 1, succeeding *Dr. Fred G. Johnson, Jr.*

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Dr. R. M. Waldkirch, De Pere, announces his association with *Dr. J. R. Goelz* of Brillion in the formation of the De Pere Clinic. An addition is being built to the present clinic.

Captain Bernard Waldkirch, now with the Army Medical Corps in Japan, will join the clinic after his discharge from the Army.

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Gundersen Foundation to Award Scholarship

The La Crosse Board of Education accepted the $300 annual scholarship award established by the Dr. Adolph Gundersen Memorial Foundation. The foundation was organized December 20, 1944, for the purpose of enabling members of the medical profession to further research and study. It was named in honor of *Dr. Adolph Gundersen*, a leading physician and surgeon for many years.

The $300 scholarship is to be awarded annually, in June, to the student graduating that year from a La Crosse high school who shall be judged by a committee representing teachers of science from the city high schools to be the outstanding student in sciences and the one most likely to make a contribution after college or university training in that field. Selection will be based upon: scholastic record in biology, chemistry, and physics; standing in a science aptitude test; and general ability in all subjects.

Officers of the foundation are: *Dr. Sigurd Gundersen*, president; *Dr. Gunnar Gundersen*, vice-president; M. P. Jonsrud, secretary-treasurer; Fred E. Steel and *Dr. Alf Gundersen*, directors.

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Dr. G. A. Parish, Mayville, has been named Chief of Staff of St. Joseph's Hospital at Beaver Dam. He will succeed *Dr. Thomas C. Clarke*, who recently resigned.

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Dr. Paul K. Edwards, physician and surgeon, has opened offices in Bloomington. A native of Boston, Doctor Edwards spent most of his life in Lancaster. He was graduated from the University of Wisconsin Medical School in 1929.

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Dr. H. G. E. Mallow of Watertown, former flight surgeon with the Army, addressed the Wethonkitha Club on Thursday, January 10, giving an account of his experiences in China, where he spent a number of months. Doctor Mallow described the building of big airfields by hand by the native Chinese; he also gave a brief account of the way the people live.

Doctor Pomainville Honored

Dr. Leland C. Pomainville, Wisconsin Rapids, was given a fellowship in the American College of Surgeons; it was conferred upon him in absentia at the annual meeting of the board of regents held recently in Chicago.

Doctor Pomainville was required to submit 50 case records of major work done in which he was the responsible surgeon. Cases submitted are judged on their individual merits as to the professional ability, training, and experience of the applicant in the particular field of surgery in which he is engaged.

The doctor served in the Medical Corps of the Navy, entering service October 11, 1943; he was discharged January 1, 1946. A 1931 graduate of the University of Wisconsin Medical School, he interned and served as house surgeon at Milwaukee County Hospital. He began his practice in 1933.

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Two doctors will rejoin the Muirdale Sanatorium Staff, replacing other key men who are leaving the Milwaukee county tuberculosis hospital. Dr. David D. Feld, assistant chief senior physician at Muirdale for ten years, and former member of the State Society, will return from California where he has been practicing for three years. Dr. Douglas A. Gutheil, senior physician at Muirdale before entering the Army four years ago, will return immediately according to information received by *Dr. A. V. Cadden,* director of the hospital.

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A fire destroyed the office of *Dr. Clemens R. Kwapy* of Oconto, secretary of the Oconto County Medical Society.

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New Division at Mount Sinai Hospital Announced

The Mount Sinai Hospital Laboratories announce the establishment of a special division devoted to the identification of tubercle bacillus by culture methods. This department will be under the technical direction of Miss Sylvia Anderson, according to an announcement by *Dr. Norbert Enzer,* director of laboratories at the hospital.

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Dr. Benjamin H. Dike, Owen physician, spoke at the December 10 meeting of the Kiwanis Club. He gave a very interesting and humorous resumé of his internship and practice of medicine. He also reviewed the advances of medical science, with a forecast of some things to be made known in the near future.

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The medical teaching services of Marquette University and the city hospitals were inspected by a study committee for the province of Manitoba, touring the midwest. Members of the committee were: Dr. Bruce Chown, Winnipeg Children's Hospital; F. W. Crawford, comptroller of the University of Manitoba; and Ivan Schultz, Manitoba minister of health and public welfare.

Dr. Henry A. Anderson, medical director of River Pines Sanatorium at Stevens Point, addressed the American Legion and auxiliary in Green Bay on Thursday evening, December 13. He spoke for the Anti-Tuberculosis Association, discussing the problem of tuberculosis among war veterans.

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Dr. Robert S. Baldwin spoke to the Marshfield Knights of Columbus on Thursday, January 10, on the prevailing trends in the field of medicine. Doctor Baldwin, who served as a lieutenant colonel in the Army Medical Corps, had ample opportunity to observe and apply the latest developments in the medical field, not only in this country but in the Pacific and European Theaters of Operations as well. The doctor discussed the discovery of penicillin by the English physician, Doctor Fleming. Doctor Baldwin cited the introduction of the miracle drugs, sulfa and penicillin, as an outstanding contribution of science in the eradication of disease, and as a direct influence in changing the problems of medicine. The effect and danger of infectious diseases are now minimized, with the emphasis in the study of medicine shifting to biochemical aspects—the processes taking place in the body.

Doctor Baldwin stressed the increased interest in the social aspects of medicine, similar to the trend following the last war.

Doctor Baldwin also spoke to the members of the Marshfield Lions Club on Tuesday, January 15, discussing malaria and its prevalence in this country with the return of soldiers from malarial areas.

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Dr. George T. Hegner was guest speaker at the community breakfast for members of the Holy Name Society of Appleton, held Sunday morning, January 13.

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Dr. Kenneth J. Denys of Green Bay, recently discharged from the service, spoke at the district meeting of the State Organization of Public Health Nursing on Friday, November 16. Doctor Denys discussed some of the problems met by doctors along the Burma Road. His particular job was to establish hospitals along the axis of the Burma Road to care for American, British, and Chinese troops, most of whom had malaria. Each hospital had 30 beds, a day's march apart, and each was manned by technicians trained there by doctors and nurses. The doctor also spoke of jungle rot prevalent in that area, resulting from leech bites.

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Wisconsin Hospital Association

The mid-year conference of the Wisconsin Hospital Association will be held at the Hotel Schroeder in Milwaukee, February 14 and 15. Some of the topics to be discussed are: the Significance of the National Hospital Survey as it Relates to Trends in the United States; Federal Aspects of Hospital and Health Service; The Care of Veterans; The Care of Indigents by Voluntary Hospitals; Postwar Aspects of Purchasing; and Trends in Nursing Education.

Chicago Medical Society Clinical Conference

The Chicago Medical Society Annual Clinical Conference will be held at the Palmer House, Chicago, March 5–8, 1946. The program committee has invited outstanding members of the medical profession to present papers of general interest to all the profession. This is the first major general meeting in Chicago since the cessation of hostilities.

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Urology Award

The American Urological Association offers an annual award "not to exceed $500" for an essay or essays on the result of some specific clinical or laboratory research in Urology. The amount of the prize is based on the merits of the work presented, and if the Committee on Scientific Research deem none of the offerings worthy, no award will be made. Competitors shall be limited to residents in urology in recognized hospitals and to urologists who have been in such specific practice for not more than five years. All interested should write the secretary for full particulars.

The selected essay or essays will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Netherland Plaza, Cincinnati, Ohio, July 22–25, 1946.

Essays must be in the hands of the Secretary, Dr. Thomas D. Moore, 899 Madison Avenue, Memphis 3, Tennessee, on or before July 1, 1946.

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Interstate Postgraduate Medical Association Assembly

The 1946 Assembly of the Interstate Postgraduate Medical Association of North America will be held at the Public Auditorium in Cleveland, Ohio, Tuesday, October 15, to Friday, October 18, 1946, inclusive.

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Annual Contest Announced

The American Association of Obstetricians, Gynecologists, and Abdominal Surgeons Foundation announces that the annual prize contest will be conducted again this year. For information address: Dr. James R. Bloss, Secretary, 418 Eleventh Street, Huntington 1, West Virginia.

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Annual Meeting of American Association of Pathologists and Bacteriologists

The annual meeting of the American Association of Pathologists and Bacteriologists will be held at the University of Chicago Friday and Saturday, March 8 and 9. Contributions to the program should be sent not later than February 16 to the office of the Secretary, Dr. Howard T. Karsner, 2085 Adelbert Road, Cleveland 6, Ohio.

American Board of Ophthalmology Examinations

Due to transportation difficulties the examination of the American Board of Ophthalmology, originally scheduled for Los Angeles, January 28 to 31, has been changed to San Francisco, June 22 to 25 inclusive.

The 1946 examinations will be held as follows: Chicago, January 18–22; New York, April 10–13 (approximately); San Francisco, June 22–25; Chicago, October 9–12.

A new ruling requires that previously accepted candidates mail their lists of surgery to the Board office at least sixty days prior to their examination. All new applicants are now required to send their list with application.

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American College of Physicians Annual Meeting

The American College of Physicians is resuming its Annual Meetings, and the 1946 meeting will be held in Philadelphia, May 13–17 inclusive. Headquarters will be at the Philadelphia Municipal Auditorium. The meetings will be conducted under the presidency of Dr. Ernest E. Irons of Chicago, and the general chairmanship of Dr. George Morris Piersol of Philadelphia.

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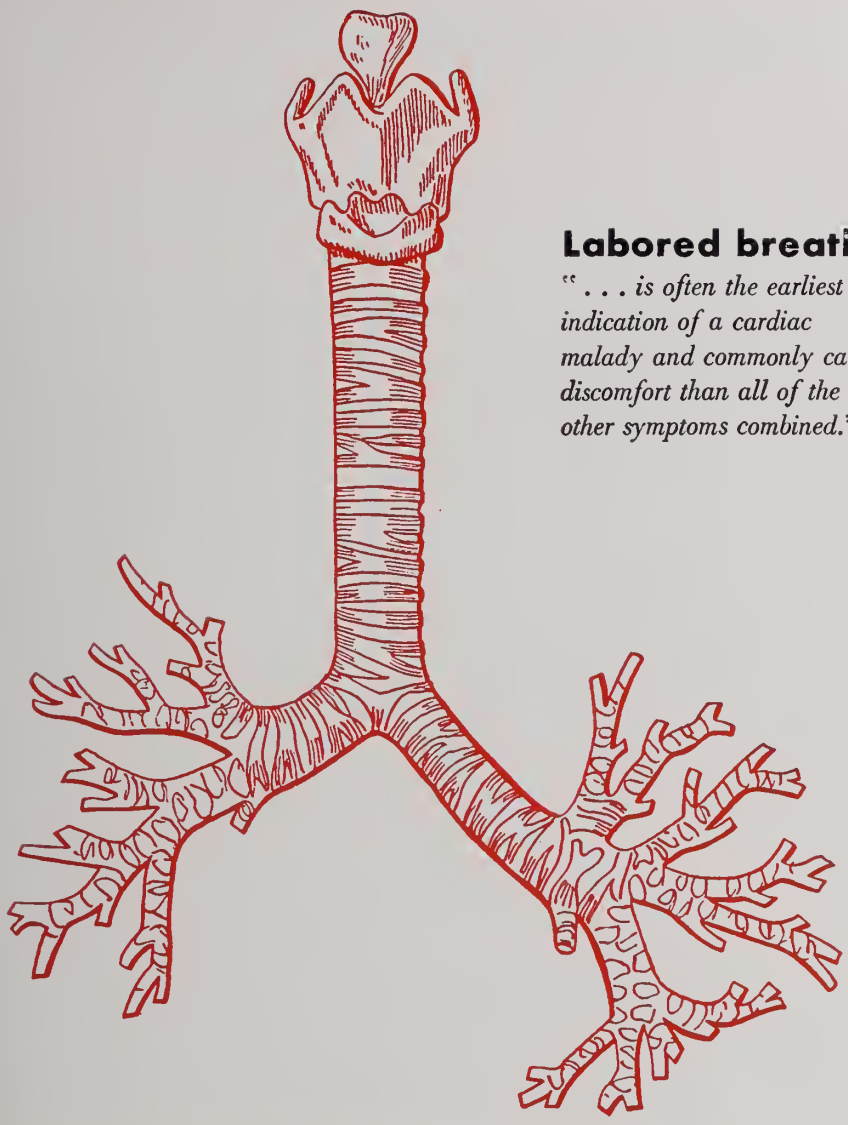
National Gastroenterological Association Contest

The National Gastroenterological Association announces the establishment of an Annual Cash Prize Award of $100 and a Certificate of Merit for the best unpublished contribution on Gastroenterology or allied subjects. Certificates will also be awarded those physicians whose contributions are deemed worthy.

Contestants residing in the United States must be members of the American Medical Association. Those residing in foreign countries must be members of a similar organization in their own country. The winning contribution will be selected by a board of impartial judges and the award is to be made at the Annual Convention Banquet of the National Gastroenterological Association to be held at the Hotel Pennsylvania in New York City on Thursday evening, June 20, 1946.

Certificates awarded to other physicians will be mailed to them. The decision of the judges will be final. The Association reserves the exclusive right of first publishing the winning contribution, and those receiving certificates of merit, in its Official Publication, *The Review of Gastroenterology*. All entries for the 1946 prize should be limited to 5,000 words, be typewritten in English, prepared in manuscript form, submitted in five copies, accompanied by an entry letter, and must be received not later than May 1, 1946. Entries should be addressed to the National Gastroenterological Association, 1819 Broadway, New York 23, N. Y.



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1. *Harrison, T. R.: Cardiac Dyspnea, Western J. Surg.*, 52:407 (Oct.) 1944.

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Society Proceedings

Ashland—Bayfield—Iron

Meeting at St. Joseph's Hospital in Ashland on December 14, the Ashland–Bayfield–Iron County Medical Society heard *Dr. Leonard W. Moody* of Bayfield speak on the "Ultimate Results in Tuberculosis, Considering Various Approved Types of Treatment."

An election of officers was held for the following year. *Dr. Leonard W. Moody*, Bayfield, was elected president: *Dr. A. D. Andrus*, Ashland, vice-president; *Dr. William E. Bargholtz*, Ashland, secretary-treasurer; *Dr. Carl W. Lockhart*, Mellen, delegate; and *Doctor Bargholtz*, alternate delegate.

Barron—Washburn—Sawyer—Burnett

The Barron–Washburn–Sawyer–Burnett County Medical Society elected the following officers for the coming year at their December 11 meeting: *Drs. Simon O. Lund*, Cumberland, president; *William B. Rydell*, Rice Lake, vice-president; *Dale V. Moen*, Shell Lake, secretary-treasurer; Lund, delegate; and Rydell, alternate delegate.

Brown—Kewaunee—Door

An election of officers was held at the December 13 meeting of the Brown–Kewaunee–Door County Medical Society. *Dr. Thomas S. Burdon*, named president-elect a year ago, became president. Other offiers named were: *Drs. Otis W. Saunders*, president-elect; *William W. Ford*, vice-president; *George M. Shinners*, secretary-treasurer; *James C. Colignon*, censor; *Saunders* and *Arthur J. McCarey*, delegates; and *Walter P. Tippet* and *Wendell A. Killins*, alternates; all are from Green Bay.

Reports were also given by *Dr. John L. Ford*, Chairman of the Cancer Committee; and *Dr. Paul M. Clifford*, Chairman of the Pension Committee.

Officers were installed at the January 10 meeting, held at the Beaumont Hotel. The organization voted full cooperation in the cancer centers to be held here in the near future. Three physicians were admitted to membership: Lieutenant Robert G. Wochos, Kewaunee, now at the Army Air Forces Station Hospital, Myrtle Beach, South Carolina; Dr. K. E. Kaufman, associated with Dr. A. L. Freedman as an orthopedist; and Dr. James S. Feurig, now with the Brusky clinic.

Calumet

Officers were elected by the Calumet County Medical Society at their December 6 meeting. *Dr. John A. Knauf*, Stockbridge, was named president; *Dr. John R. Goelz*, Brillion, secretary-treasurer; *Dr. Adolph C. Engel*, New Holstein, delegate; and *Dr. Nicholas J. Knauf*, Chilton, alternate. *Dr. Creighton A. Hardin*, Clinton, was accepted for membership.

Chippewa

Dr. Clarence E. Zenner, Cadott, was elected president of the Chippewa County Medical Society at their December 3 meeting. Other officers elected were: *Drs. C. B. Hatleberg*, vice-president; and *S. E. Williams*, secretary. Both are from Chippewa Falls. Doctor Williams was also named delegate.

A scientific program was presented by the Jackson Clinic of Madison; papers were read by Drs. M. Dickerson, *Roger E. Henning*, and *L. Elizabeth Henning*

Dodge

The Dodge County Medical Society met at the Hotel Rogers, Beaver Dam, on Thursday, December 20, to hear *Dr. J. S. Supernaw* of Madison discuss the Watkins operation, illustrating his talk with colored films. He also explained "the Wisconsin Plan" for prepaid medical insurance in detail. After a general discussion of the subject, the members agreed to support the plan.

Dr. Harold E. Marsh of Madison addressed the society on the treatment of various cardiac conditions at the meeting held Thursday, January 24.

Douglas

Dr. Herbert J. Orchard of Superior, who has completed fifty years in the medical profession, was honored by the Douglas County Medical Society at its meeting Wednesday night, December 5, at the Hotel Superior. He was presented with a gold medal in token of his service, and became the fourth doctor to be so honored by the society; others were *Drs. W. E. Ground, Loran W. Beebe*, and the late *John Baird*. Doctor Orchard is a past president of the society, and of the Inter-Urban Academy of Medicine.

Another feature of the meeting was a speech by Dr. George J. Hathaway, recently returned from service with the Army, who related his war experiences.

Meeting on January 2, the Douglas County Society was addressed by *Dr. Conrad W. Giesen* of Superior, who discussed "Ruptured Aortic Aneurysm;" and *Dr. Herbert B. Christianson* of Superior who spoke on "Congenital Heart Disease with Subacute Bacterial Endocarditis." The City Health Department was discussed and a committee appointed to make recommendations at the following meeting.

Eau Claire—Dunn—Pepin

A social meeting of the Eau Claire–Dunn–Pepin County Medical Society was held December 17 at the Elks Club in Eau Claire. The purpose of the meeting was to welcome back the doctors who have been serving in the armed forces.

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Officers of the society elected for the following year are: *Drs. Horace S. Fuson*, Eau Claire, president; *R. N. Leasum*, Osseo, vice-president; *William T. Mautz*, Eau Claire, secretary-treasurer; *Walton R. Manz*, Eau Claire, delegate; *Ben F. Johnson*, Mondovi, alternate; and *George W. Beebe* and *J. E. B. Ziegler*, Eau Claire, censors.

At its January 28 meeting, the society heard Dr. Ray Shannon of St. Paul discuss "Problems in Pediatrics."

Jefferson

Officers for the year 1946 were elected at the December 13 meeting of the Jefferson County Medical Society, as follows: *Drs. Louis H. Gueldner*, Fort Atkinson, president; *John J. Harris*, Fort Atkinson, vice-president; *H. G. E. Mallow*, Watertown, secretary-treasurer; *Gustave E. Eck*, Lake Mills, delegate; and *Otto F. Dierker*, Watertown, alternate.

Members who have returned from the service are *Drs. John J. Harris*, Fort Atkinson, and *Louis W. Nowack* and *H. G. E Mallow* of Watertown

At the January 17 meeting Doctor Mallow related some of his experiences in China while serving with the Army Air Forces.

Kenosha

Holding their regular December dinner meeting at Radigan's Tuesday, December 18, the Kenosha County Medical Society installed its new officers, with *Dr. Irvin E. Bowing*, retiring president, acting as installing officer. Officers installed were: *Drs. Ben S. Hill*, president; *Joseph P. Graves*, president-elect; *Charles F. Ulrich*, secretary-treasurer; and *W. C. Stewart*, delegate.

Three members of the society were welcomed back from the armed forces: *Captain Harry L. Schwartz*, *Lieutenant Commander Walter C. Kleinpell*, and *Lieutenant Commander George C. Schulte.*

La Crosse

The La Crosse County Medical Society met at the Stoddard Hotel, La Crosse, on Tuesday evening, December 11. The speaker was Oscar Kanner of St. Francis Hospital, who discussed "Laboratory Work and Its Relationship to Clinical Diagnosis."

The following officers were elected: *Drs. George R. Reay*, president; *D. F. Doyle*, vice-president; and *Joseph F. Egan*, secretary-treasurer; all officers reside in La Crosse.

At its January 22 meeting the society heard Dr. W. H. Deering, of the Mayo Clinic at Rochester, discuss "Diverticulitis."

Manitowoc

Members of the Manitowoc County Medical Society, meeting at the Hotel Manitowoc on December 20, heard explanations of the two insurance plans for hospitalization and medical care, one sponsored by the State Medical Society and the other by the Medical Society of Milwaukee County. *Dr. Lyman A. Copps*, Marshfield, explained "The Wisconsin Plan," and *Dr. J. W. Fons*, Milwaukee, spoke on the plan sponsored by the Milwaukee group. Manitowoc physicians took no action in endorsing either plan.

Marathon

The Marathon County Medical Society held its annual meeting December 19 at the Wausau Hotel. The following officers were elected: *Drs. Otis M. Wilson*, president; *Harold H. Fechtner*, president-elect; *A. W. Burek*, secretary-treasurer; and *E. E. Fleming* and *H. H. Christensen*, delegates.

Milwaukee

The Medical Society of Milwaukee County held its annual meeting on Thursday, December 13, in the Plankinton Hotel. After the installation of *Dr. Lucius W. Hipke* as president, officers were elected at the business session. The following men had been nominated: *Drs. Urban A. Schlueter*, president-elect; *Louis H. Kretchmar*, secretary; *John D. Steele*, treasurer; *Harry R. Foerster*, director; *Robert F. Purtell* and *John J. Pink*, censors; and the following were nominated as delegates—*Drs. William A. Ryan, Milton C. Borman, Frank E. Drew, Chester M. Echols, Norbert Enzer, Jerome W. Fons, John W. Truitt, Thomas F. McCormick*, and *Robert F. Purtell.*

Merryle Stanley Rukeyser, outstanding lecturer, journalist, economist, and author addressed the meeting.

Meeting at the Athletic Club on Friday, January 11, the society was addressed by Dr. Summer L. Koch, noted Chicago plastic surgeon and associate professor of surgery at Northwestern University Medical School, who spoke on "The Treatment of Open Wounds."

Dr. John W. Truitt, chairman of the Surgical Care Committee of the society, presented his "Report on the Progress of Surgical Care."

Outagamie

An election of officers was held by the Outagamie County Medical Society, which met at the Conway Hotel, Appleton, on December 6. The Woman's Auxiliary joined the society at dinner, but separate business sessions followed.

The medical society held an election of 1946 officers with the following results: *Drs. Donald W. Curtin*, Kimberly, president; *Francis J. Huberty*, Appleton, vice-president; and *Arthur C. Taylor*, Appleton, secretary-treasurer.

A major portion of the meeting was devoted to a report by Dr. G. W. Carlson, as delegate, and to a discussion of "The Wisconsin Plan" by *Dr. H. H. Christofferson* of Colby.

At the January 17 meeting *Dr. Ralph M. Waters*, professor of anesthesia at the University of Wisconsin Medical School, spoke on "Anesthesiology in Small Hospitals and Small Cities and Towns."

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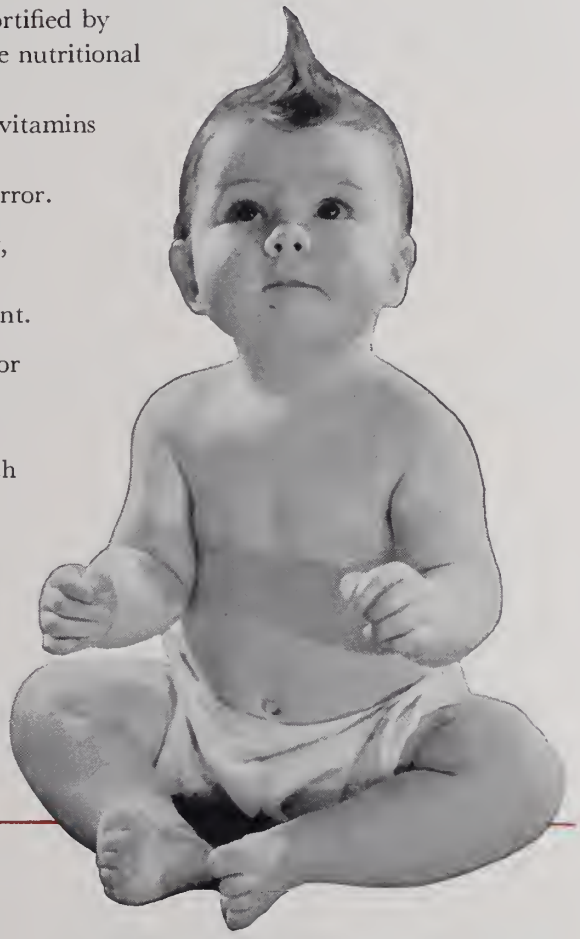

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Pierce—St. Croix

Meeting at the River Falls Clinic on January 17, the Pierce–St. Croix County Medical Society heard *Dr. C. A. Dawson* discuss "Problems and Activities of the State Board of Medical Examiners."

Richland

At its November 30 meeting the Richland County Medical Society was addressed by *Dr. R. T. Cooksey* of Madison. *Dr. J. S. Supernaw*, also of Madison, discussed "The Wisconsin Plan."

At its December meeting the society held an election of officers. *Dr. Gideon H. Benson*, Richland Center, was named president; *R. E. Housner*, vice-president; *W. C. Edwards*, secretary-treasurer; *C. A. Sholtes*, censor; *George Parke, Sr.*, delegate; and *Donald J. Taft*, alternate. All the doctors are from Richland Center except Doctor Parke, who is from Viola.

Rusk

The Rusk County Medical Society met at St. Mary's Hospital, Ladysmith, on January 10, for its annual election of officers. They were as follows: *Drs. W. F. O'Connor*, Ladysmith, president; *Maurice L. Whalen*, Bruce, secretary; *Lambert M. Lundmark*, Ladysmith, delegate; and *Woodruff Smith*, Ladysmith, alternate.

A report was given by the Goiter Committee, whose members are: *Drs. Woodruff Smith, William B. A. J. Bauer*, and *Howard F. Pagel*, all of Ladysmith.

Shawano

At their meeting held December 11 the Shawano County Medical Society elected the following officers for 1946: *Drs. Alois J. Sebesta*, president; *Frederick Bauer*, vice-president; *Hector C. Marsh*, secretary-treasurer; *Arthur A. Cantwell*, delegate; and *Edward E. McCandless*, alternate. All the officers are from Shawano except Doctor McCandless, who is from Birnamwood.

Sheboygan

The Sheboygan County Medical Society met at the Sheboygan Memorial Hospital on December 11 and saw a sound movie entitled "The Physiology of Anoxia." There was a discussion of "The Wisconsin Plan" and the Milwaukee Surgical Care Plan.

At the January 22 meeting, held at St. Nicholas Hospital, Sheboygan, the society heard short talks on the interesting aspects of military life, given by doctors returned from service. Those particiapting were *Drs. Harry H. Heiden, Jerry W. McRoberts, John E. Martineau, Edward G. Schott, Willard G. Huibregtse*, and Homer H. Kohler. All the doctors are from Sheboygan except Doctor Martineau, who is from Elkhart Lake.

An election of officers was held. It was voted to request the Bureau of Handicapped Children to reappoint *Dr. Herman W. Wirka*, Madison, as the consultant orthopedist for the Crippled Children's Clinic.

Trempealeau—Jackson—Buffalo

Dr. George B. Ridout of the Gundersen Clinic, La Crosse, spoke on the diagnosis, complications, and treatment of the cold at the monthly meeting of the Tri-County Medical Society, held at the Kostner Hotel in Arcadia Thursday, October 18. Members who attended the meeting of the House of Delegates of the State Society were: *Drs. Elizabeth Comstock* and *Frank T. Weber*, Arcadia; *R. L. MacCornack* and *Neal S. Simons*, Whitehall; *Donald R. Peterson*, Independence; *Richardo L. Alvarez*, Galesville; and *Robert Krohn*, Black River Falls.

The Trempealeau–Jackson–Buffalo County Medical Society held its annual meeting at Whitehall Thursday, November 15, and the following officers were elected, after *Dr. James C. Tyvand*, Whitehall, president-elect for the past year, was installed: *Drs. Donald R. Peterson*, Independence, president-elect; *Richardo L. Alvarez*, re-elect secretary; and *Robert Krohn*, Black River Falls, delegate.

After a dinner meeting, the group adjourned to the MacCornack Clinic to hear a report of the House of Delegates meeting.

Washington—Ozaukee

Meeting at the St. Alphonsus Hospital, Port Washington, the Washington–Ozaukee County Medical Society heard *Dr. Max J. Fox* of Milwaukee deliver an interesting and informative paper on "Poliomyelitis."

At their January 24 meeting the society heard *Dr. Maurice Hardgrove* of Milwaukee discuss tropical medicine and his experiences while stationed in Panama. During the business meeting *Drs. H. Meyer Lynch*, West Bend; *John G. Hoffman*, Hartford; and *William H. Driesen*, Port Washington were appointed to the Committee on Goiter. *Dr. H. V. Crum*, now associated with *Dr. Arnold H. Barr* of Port Washington, was elected a member; *Dr. Henry Katz* was voted a War Member.

Walworth

The Walworth County Medical Society met at the Colonial Hotel in Delavan, Thursday, January 17, to hear Mr. C. H. Crownhart, secretary of the State Society, discuss "The Wisconsin Plan."

Winnebago

At a meeting held at the Hotel Athearn, Oshkosh, Thursday, December 6, the Winnebago County Medical Society held its annual election of officers. The following doctors were elected for the year 1946: *Drs. Byron J. Hughes*, Winnebago State Hospital, president; *T. E. Kilkenny*, Winneconne, vice-president; *Marvin H. Steen*, Oshkosh, secretary-treasurer; *Gerhard R. Anderson*, Neenah, delegate; and *William A. Wagner*, Oshkosh, alternate.

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The following were accepted into membership: Drs. J. R. Nebel, Menasha; A. P. Graham, Neenah, transferred from Chicago County Medical Society; and David M. Regan, Neenah, transferred from Waushara, Green Lake County Medical Society. War memberships were granted Lieutenant Harold Q. Danforth and Captain George Hildebrand.

The society met at Valley Inn, Neenah, on January 3, and heard *Dr. H. H. Christofferson* of Colby discuss "The Wisconsin Plan of Prepaid Surgical, Obstetric, and Hospital Care Insurance."

Milwaukee Academy of Medicine

A joint meeting of the Milwaukee Academy of Medicine and the Milwaukee Roentgen Ray Society was held at the University Club on Tuesday, December 18. Dr. A. U. Desjardins, head of the department of Therapeutic Radiology at the Mayo Clinic, addressed the meeting on the subject: "Roentgen Rays as a Method of Distinguishing Different Varieties of Tumors." Doctor Desjardins assumed charge of the department in 1920 and has done extensive work in radiotherapeutics; he is the author of many articles on the subject.

At the academy's January 15 meeting *Dr. Frederick W. Madison*, incoming president, stated that a major aim of the group for the year would be the encouragement and promotion of adequate training for young doctors and interns in the Milwaukee area. Maintaining an adequate library, presenting discussions of current medical subjects by distinguished specialists, and fostering the growth and development of young men to whom will be entrusted the practice of medicine in the future, were also stressed as important.

The speaker for the evening was *Dean William S. Middleton* of the University of Wisconsin Medical School, who talked on "War and Medicine." He pointed out the acceleration of medical knowledge during the war, particularly in the fields of the sulfa drugs, penicillin, and the control of epidemics.

Dr. Robert G. Washburn was given an honorary membership by *Dr. Carl W. Eberbach*, retiring president. Doctor Washburn was one of the nine founders of the academy.

Doctor Eberbach announced that thirty-three members have served in the armed forces; twenty-one of these have returned to civilian life.

Milwaukee Neuro-Psychiatric Society

At a meeting held at the Athletic Club on Thursday, January 24, *Dr. Hans H. Reese* of Madison discussed his experiences with the War Department and the Army Air Forces. Films of Neurologic Conditions, from the New York University Film Library, were shown.

American College of Surgeons

The first of a series of ten sectional meetings of the American College of Surgeons was held in Minneapolis on January 28 and 29. Participating states and provinces were: Minnesota, North Dakota, South Dakota, Nebraska, Iowa, Wisconsin, Saskatchewan, and Manitoba. Dr. James M. Hayes, assistant professor of surgeory at the University of Minnesota Medical School, headed the arrangements committee and conducted the clinical conference.

Some of the subjects discussed were: "Treatment of Infection by Chemotherapy and the Antibiotics," "Injuries to the Bile Ducts," "The Care of the Veteran," "Pre- and Postoperative Supportive Treatment," "Treatment of Open Wounds," "Graduate Training in Surgery," "The Reconversion Period in the Practice of Medicine," "Treatment of Osteomyelitis," and "Management of Advanced Cancer."

Later meetings will be held in St. Louis, Birmingham, Pittsburgh, Boston, Montreal, Detroit, Salt Lake City, Portland, and Los Angeles. The medical profession at large, medical students, and hospital executives are invited to join with the Fellows of the college in these meetings, which will be addressed by nationally prominent visiting and local speakers.

Interurban Academy of Medicine

At the annual meeting of the Interurban Academy of Medicine, *Dr. Henry A. Sincock* of Superior was elected president. He succeeds Dr. Olin W. Rowe of Duluth.

American Academy of Ophthalmology and Otolaryngology

The American Academy of Ophthalmology and Otolaryngology has plans for a nationwide program of detection and treatment of the hard of hearing child.

Plans call for a director of hearing conservation in each state, probably working in collaboration with the state medical society and the state department of public health and welfare.

It is hoped that checks can be made of the hearing in all school children at least once in three years. It is also desired that there be established in every large city a Hearing Rehabilitation Clinic under the management of local otologists who will diagnose the type of impairment and make suggestions as to treatment and rehabilitation.

No treatment will be done at these clinics. The patients will be referred back to their own otologists with a report of the clinic's findings and suggestions as to treatment. In the event that the patient has no ear doctor he is referred to the secretary of the county medical society, who will recommend someone to take care of the child. In no instance is the patient seen privately by the otologist in the clinic.

Milwaukee Oto-Ophthalmic Society

Meeting at the Athletic Club on Tuesday, January 22, the Milwaukee Oto-Ophthalmic Society heard Dr. Avery D. Prangen of the Mayo Clinic talk on "Some Clinical Aspects of Refraction."

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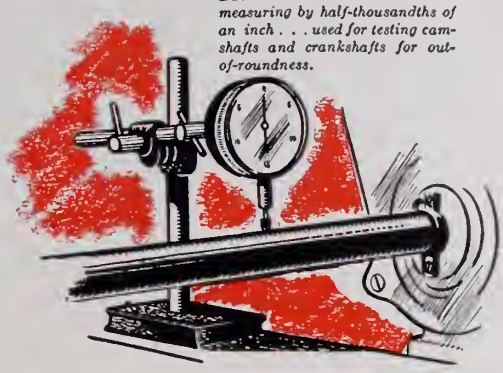

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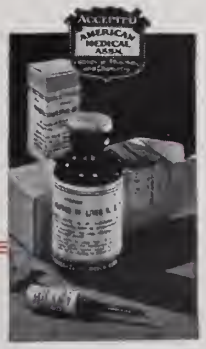

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—EDITOR'S NOTE

SOCIETY PROCEEDINGS

Columbia—Marquette—Adams

The Columbia–Marquette–Adams County Medical Society met at St. Savior's Hospital in Portage, on Thursday, December 6. *Dr. L. V. MacNamara* of Montello, the society's president, had moved to Milwaukee, so *Dr. E. J. Tierney* of Portage assumed the chair.

At its January 10 meeting, held at the Raulf Hotel in Portage, *Dr. C. O. Vingom* of Madison discussed "The Wisconsin Plan." An open discussion followed.

An election of officers was held with the following results: *Drs. Edward F. Tierney*, Portage, president; *Raymond B. Dryer*, Poynette, president-elect; *John H. Houghton*, Wisconsin Dells, secretary-treasurer; *Tierney*, delegate; and *Dryer*, alternate.

Dane

Meeting at the Madison Club on Tuesday, December 11, members of the Dane County Medical Society were addressed by *Dr. Henry L. Greene*, speaking on the subject of Fractures; a movie and roentgenograms were shown. A discussion by *Drs. James A. Jackson, Herman W. Wirka*, and *Arthur G. Sullivan* followed.

Dr. H. V. Bancroft was made an honorary member of the society, and Dr. Stella Sikkema was accepted for full membership; Drs. Franklin Dowiasch and James E. Miller were accepted as resident members.

At their January 8 meeting *Dr. Charles J. Thill* of the Department of Internal Medicine at the University discussed "Oral Penicillin Therapy." There was a discussion by *Drs. Robert J. Kinney, N. A. Hill*, and *Philip M. Cornwell*.

Rock

Dr. John W. Harris, professor of obstetrics and gynecology at the University of Wisconsin Medical School, was the speaker at the November 27 meeting of the Rock County Medical Society, held at the Monterey Hotel in Janesville. His subject was "Recent Clinical Advances in Obstetrics."

Madison Society of Medical Technologists

Dr. Frederick J. Pohle of the Wisconsin General Hospital spoke at the December 5 meeting of the Madison Society of Medical Technologists.

University of Wisconsin Medical Society

Harold F. Deutsch, Ph. D., assistant professor of physiological chemistry and research associate in physical chemistry at the University, was the speaker at the December 4 meeting of the University of Wisconsin Medical Society. Doctor Deutsch discussed "Present Knowledge of Normal Human Blood Plasma Proteins." For the past several years he has been engaged in this field of research in the physical chemistry division at Wisconsin. Government sponsorship during the war tremendously accelerated knowledge in the separation and clinical application of human blood plasma proteins. The latter phase of these studies was done in cooperation with the department of physical chemistry of the Harvard Medical School.

At the January 3 meeting the society was presented with a symposium on "The State Program for the Control of Rheumatic Fever" with *Drs. H. Kent Tenney, Kenneth B. McDonough*, and *Chester M. Kurtz* participating.

Lieutenant Colonel Baldwin Lucke, D.P.H., M.D., professor of pathology, on leave from the University of Pennsylvania, spoke on "The Lower Nephron Syndrome" at the January 17 meeting. Doctor Lucke occupies a leading position in the field of experimental pathology and has been especially interested in cell permeability as well as tumors of cold blooded animals. During the war years he has devoted his time to a study of epidemic hepatitis in the Army and to the kidney lesions that occurred in troops as a result of severe trauma, blood transfusions, etc. He is the deputy director of the Army Institute of Pathology.

The University of Wisconsin Medical Society meets in the Service Memorial Institutes building, Madison.

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COUNCILOR DISTRICT NEWS

Fluorine Study Group Named

Dr. E. L. Sevringhaus, professor of medicine at the University of Wisconsin, was elected chairman, and Dr. Bernard Domagalla, city biochemist with the State Board of Health, was named secretary of the Madison Fluorine Research Committee at the organization meeting of the newly appointed group, held Friday, December 7.

Doctor Sevringhaus tentatively named four subcommittees to study: (1) technical control methods in adding fluorine to the city water supply, (2) the advantages and risks of using fluorine to prevent dental decay, (3) possible alternative methods of accomplishing the same result, and (4) chemical control methods.

The committee was authorized by the common council November 23 to study the proposal to add fluorine to the city's water supply with the view of controlling dental caries; it is to report its recommendations to the council within three months.

The fluorine committees of the Dane County Dental and Medical Societies had earlier recommended that the "Fluorine concentration of Madison's water supply be increased to one part per million" to inhibit dental decay.

Members of the committee are: *Drs. Sevringhaus, Albert R. Tormey, N. A. Hill,* and *John E. Gonce, Jr.*, physicians; Drs. H. E. Devereaux, J. S. Dreher, and R. W. Huegel, dentists; Dr. Daniel M. Angevine, university toxicologist; University professors C. A. Elvehjem and E. B. Hart, biochemists; V. W. Meloche, chemist; Elizabeth McCoy, bacteriologist; O. L. Kowalke, chemical engineer; C. N. Ward, hydraulic engineer; and Mrs. Patrick Hyland, president of the Catholic Women's Club, layman member.

Madison Surgeon Honored

Dr. Henry L. Greene, Madison orthopedic surgeon, has been signally honored by the National University of Mexico at Mexico City for his course of lectures given there in the summer on the practice and treatment of bone and joint surgery. He left last August and taught at the National University through September.

Doctor Greene has been made an honorary professor of the university, the largest federal institution of higher learning in Mexico.

Medical School Cited by Navy

A certificate, citing the University of Wisconsin Medical School for effective cooperation in the training of naval officer candidates, was accepted on January 10 by *Dean Walter J. Meek* in a ceremony held in the campus naval base office. The award was made by Captain Jack Hurff, Commanding Officer of the University NROTC units. *Dr. Harold M. Coon*, Superintendent of the Wisconsin General Hospital, was also present.

The citation, signed by Secretary of the Navy James V. Forrestal, states: "For effective cooperation with the United States Navy in the training of officer candidates in naval V-12 program during World War II."

Dean Meek accepted the award in the absence of *Dr. William S. Middleton*, Dean of the University Medical School. Doctor Meek was in charge of the school when Doctor Middleton was on leave in the military service.

Heart Association Formed

Incorporation papers for the Wisconsin Heart Association, an organization to sponsor and assist in a state program for the prevention of heart disease, were filed in the Secretary of State's office December 3.

Incorporators are: *Drs. Ovid O. Meyer, N. A. Hill, Chester M. Kurtz*, Madison; *Alvin G. Koehler*, Oshkosh; and *Vincent M. Koch*, Janesville.

Incorporation papers of this non-stock, non-profit organization state that it would promote and assist in the continued education of the medical profession in the prevention and proper treatment of heart disease. It will also promote and assist in an education program for parents, teachers, and others in the proper treatment of the disease—particularly rheumatic heart disease.

Monroe Surgeon Honored

Dr. William B. Gnagi of Monroe was honored December 7 when the International College of Surgeons conferred on him the degree of fellow. The organization, now of world fame, began in Switzerland. Doctor Gnagi went to Washington to receive the fellowship.

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Madison Woman Doctor in Japan

Dr. Mae Josephine O'Donnell of Madison was among thirty-three women to land at Nagoya, on November 24, the first to land since the port opened on October 28. Doctor O'Donnell was one of two doctors in the party, who will serve at the 307th Hospital at Osaka.

Doctor Sevringhaus Leaves University

Dr. Elmer L. Sevringhaus, professor of medicine at the University and staff member of the Wisconsin General Hospital, has resigned from the medical faculty to become director of clinical research for Hoffman La Roche, Inc., international drug firm with headquarters at Nutley, New Jersey. The physician, widely known for his research, practice, and writing on metabolic medicine, will leave Madison in March.

Doctor Sevringhaus will direct doctors and medical scientists in the development and clinical evaluation of new drugs produced in the laboratories of the firm, which originated in Basel, Switzerland. Hoffman La Roche is the American affiliate, and the company has subsidiaries in France and England.

Doctor Sevringhaus came to Madison in 1921 after his graduation from Harvard Medical School, and has served on the medical faculty ever since. During this war he went to Italy, serving on a nutritional project for UNRRA.

Veterans Hospital to Be Located in Madison

General Omar Bradley has announced that Madison will be the site of a $4,250,000 Veterans Administration tuberculosis hospital. All plans are tentative and no further details are as yet available.

Doctor Kurtz Speaks

Dr. Chester M. Kurtz, Madison, heart specialist and authority on rheumatic fever, spoke at the Edgerton high school on December 3. He also addressed the Lowell PTA in Madison on January 16. Doctor Kurtz is a frequent speaker on the prevention of rheumatic fever.

Doctor Reed Named Medical Director

Dr. Howard L. Reed has been appointed assistant medical director of Hercules Powder Company, according to an announcement by Dr. Lemuel C. McGee, Hercules medical director.

Doctor Reed has been medical director of the Hercules-operated Sunflower Ordnance Works in Kansas for the past two years. Prior to that, he was medical director of the Hercules-operated Badger Ordnance Works in Wisconsin.

A graduate of Duke University and Duke Medical School, he served as interne and resident physician at Roosevelt Hospital in New York City for nearly three years before joining Hercules in Wisconsin in March of 1942.

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New Members

Harold J. Danforth, 12 Elmwood Avenue, Oshkosh.

Albert P. Graham, 118½ West Wisconsin Avenue, Neenah.

Jamil T. LaHam, Ripon State Bank Building, Ripon.

James F. Hildebrand, Menasha.

Emmet R. Killeen, Minahan-McCormick Building, Green Bay.

Creighton A. Hardin, Chilton.

James W. Christofferson, 116 High Street, Waupaca.

Floyd A. Svec, Ellsworth.

Christine Thelen, 2212 Rowley Avenue, Madison 5.

Fritz Kant, 1300 University Avenue, Madison 6.

Marc J. Musser, Jr., 1300 University Avenue, Madison 6.

Stella M. H. Sikkems, 1300 University Avenue, Madison 6.

Marvin N. Golper, 2615 Cramer Street, Milwaukee.

William A. Brah, 2836 North Grant Street, Milwaukee.

Reuben J. Snartemo, 3213 West Lapham Street, Milwaukee.

Irvin L. Schroeder, 4190 North Fifteenth Street, Milwaukee.

Glenn E. Lembert, 2109 North Fifty-sixth Street, Milwaukee.

Wilson Weisel, 425 East Wisconsin Avenue, Milwaukee 2.

Philip H. Seefeld, 425 East Wisconsin Avenue, Milwaukee 2.

Joseph M. Regan, 161 West Wisconsin Avenue, Milwaukee 3.

Harry P. Maxwell, 208 East Wisconsin Avenue, Milwaukee 2.

Lee E. Miller, 5831 West National Avenue, Milwaukee.

Zachary Slomovitz, 836 West Mitchell Street, Milwaukee.

Maxon E. Margoles, 212 West Wisconsin Avenue, Milwaukee 3.

Clarence J. Kocovsky, 7511 West North Avenue, Milwaukee.

Robert R. Brazy, 3851 North Fifty-third Street, Milwaukee.

Emanuel M. Oxman, 2334 North Fourteenth Street, Milwaukee.

Changes in Address

P. M. Wilkinson, Oconomowoc, to Milwaukee County Hospital, Wauwatosa 13.

H. P. Dohn, Milwaukee, to 800 N. E. Thirteenth Street, Oklahoma City, Oklahoma.

D. W. McCormick, Shawano, to 1412 North Twenty-ninth Street, Milwaukee 8.

F. C. Binnewies, Janesville, to 138 East Harvard Avenue, Orlando, Florida.

O. R. McMurry, Greendale, to 7037 West Greenfield Avenue, West Allis 14.

V. F. Neu, Sheboygan, to Northern Building, Green Bay.

M. F. Regner, Port Washington, to 710 Leonard Street, Madison.

C. R. Brillman, Milwaukee, to 4821 South Packard, Avenue, Cudahy.

W. H. Schuler, Fennimore, to 1809 Jefferson Street, Madison.

E. L. Everts, Milwaukee, to Friedbacker-Everts Clinic, 1700 South Sixtieth Street, West Allis 14.

J. P. Semmons, Milwaukee, to 408 East State Street, Ithaca, New York.

K. E. Kassowitz, Wauwatosa, to 3321 North Summit Avenue, Milwaukee 11.

L. L. Sanford, Wauwatosa, Veterans Administration, Wood.

I. F. Thompson, Racine, to Route 4, Box 8C, Beloit.

L. F. Kaiser, Mt. Vernon, Illinois, to 4118 Cherokee Drive, Madison.

Rosaline L. Wilhelm, Madison, to Ashland.

C. L. Qualls, Sheboygan, to Beaver Dam.

Carl Milchen, Prairie du Chien, to General Delivery, Boscobel.

C. H. Perkins, Rockford, Illinois, to 615 Park Avenue, Hot Springs, Arkansas.

J. S. Vedder, Marshfield, to 1300 University Avenue, Madison 6.

R. E. Graber, Stanley, to Chippewa Falls.

BIRTH

A daughter to Dr. and Mrs. Leland C. Pomainville, Wisconsin Rapids, on January 8.

MARRIAGE

Dr. Wayne J. Fencil, Monroe, and Miss Mary Jane Doherty, Milwaukee.

DEATHS

Dr. H. E. Bedley, practicing in the vicinity of Rock Falls for many years, died Wednesday, December 5, at his home in Meridian, at the age of 83.

Doctor Bedley was formerly a member of the Dunn–Pepin County Medical Society and the State Medical Society. He was graduated from Barnes Medical College, St. Louis, in 1908.

Dr. William H. Schnell, 60, for thirty-three years a practicing physician in Superior, died Sunday, December 9, in a local hospital after a long illness.

A 1912 graduate of Milwaukee Medical College, Doctor Schnell served his internship in St. Mary's Hospital, Superior. Specializing in industrial surgery, the doctor formerly served as chief of staff of St. Mary's Hospital, chief surgeon of the Great Northern Railway, chief surgeon of the Soo Line Railway, and chief surgeon of the United States Public Health Service.

Doctor Schnell was a member of the Douglas County Medical Society, the State Medical Society, and a Fellow in the American Medical Association.

His wife and two sons survive.

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COLLEGE OF PHYSICIANS OF PHILADELPHIA

Dr. William C. Comee, 59, Green Bay physician, died in a local hospital following a long illness.

Doctor Comee graduated from the University of Illinois College of Medicine in 1908, and began his practice in Green Bay in 1920, specializing in ophthalmology, otology, laryngology, and rhinology.

Doctor Comee held membership in the Brown–Kewaunee–Door County Medical Society, the State Medical Society, the American Board of Otolaryngology, the American Academy of Ophthalmology and Otolaryngology, the American College of Surgeons, and was a Fellow in the American Medical Association.

He is survived by one son.

Dr. James R. Kellogg, Portage, died at his home Sunday, November 25, of a heart attack. He was 70 years old.

Doctor Kellogg was graduated from the University of Illinois College of Medicine in 1901, and joined his father, the late Dr. A. C. Kellogg, in practice in Portage at that time. He was formerly a member of the Columbia County Medical Society and the State Medical Society. For the past year he served as Selective Service Board Examiner for Columbia County.

He is survived by his wife, one daughter, and one son.

Dr. Charles E. Lauder, Viroqua's oldest physician, died at a Rochester hospital on Thursday, December 6, after an illness of two weeks. He was 79 years of age.

Doctor Lauder started practicing in Viroqua in 1902, and his forty-three years of practice were interrupted only by his service with the Army Medical Corps during the first World War. He enlisted at the outbreak of the war and served as a captain at Fort Sheridan, Illinois, and Camp Pike, Arkansas.

During the last ten years Doctor Lauder gave most of his time to his work as city health officer, as he was unable to continue his large country practice.

Graduated from the University of Maryland School of Medicine in 1891, Doctor Lauder was formerly a member of the Vernon County Medical Society and the State Medical Society. He served as secretary of the county society in 1903-1904.

Survivors include his wife and two daughters.

Dr. George R. Randall, 63, a member of the Veterans Administration medical staff at Wood, Wisconsin, died Wednesday, December 12, after a long illness.

Doctor Randall was born in Kingston, Ontario, and was graduated from the Queen's University Faculty of Medicine in 1905. He went to South Milwaukee at that time and practiced there, also serving as health officer for two terms. He then moved to Milwaukee and served as assistant to the late Dr. William Malone at Hanover Hospital (now St. Luke's), until his enlistment in the Army Medical Corps during the first World War. During the second World War, the doctor was stationed at the Milwaukee induction center.

Doctor Randall was a member of the Medical Society of Milwaukee County and the State Medical Society.

His wife survives.

Dr. Charles H. Mason, 72, Superior, former city health commissioner, died in a local hospital Sunday, December 30.

Widely known as a physician and surgeon, Doctor Mason had practiced medicine in Superior for forty-five years.

Graduating in 1899 from the Minneapolis College of Physicians and Surgeons, Doctor Mason began his practice at Clinton, Minnesota. His practice in Superior began in 1900. A specialist in public health, the doctor was named as city health commissioner in 1935. During his medical career he also served as chief of staff of St. Mary's and St. Joseph's Hospitals.

Doctor Mason was a member of the Douglas County Medical Society and the State Medical Society.

He is survived by his wife.

Dr. Emanuel A. Charbonneau, former Superior physician, died in a hospital in Auburn, California, on Friday, November 23, after a long illness. He was 63.

After graduating from Milwaukee Medical College in 1909, Doctor Charbonneau went to Hurley, where he practiced for a year and a half. He then moved to Superior, where he remained for over twenty-five years. At that time he moved to California.

A veteran of World War I, the doctor re-enlisted in World War II and served with the Army Medical Corps at Camp Tracy, California, and Seattle, Washington. He became ill while in service.

Doctor Charbonneau was formerly a member of the Douglas County Medical Society and the State Medical Society.

Surviving are his wife and two sons.

Dr. Leonard H. Crane, Menasha physician, died at a New London hospital on Monday, January 7, at the age of 66. He had been ill for several years.

Doctor Crane was graduated from Milwaukee Medical College in 1903. He was a practicing physician and surgeon at Dorchester for about twenty-five years, and then practiced at Hortonville, Menasha, and Manawa. He had been located at Menasha since 1939.

The doctor is survived by his wife and one son.

Dr. Ulysses S. G. Keller, 78, retired physician and former research worker in the University of Wisconsin chemistry department, died in Grand Rapids, Michigan, on Monday, January 14. He had been in ill health for several weeks.

Doctor Keller was graduated from the George Washington University School of Medicine, Wash-

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ington, D. C., in 1895. He practiced medicine in Warren, Illinois, before retiring and coming to the university.

Surviving are his wife, one daughter, and two sons.

Dr. Alexander W. Adamski, 35, Racine, died on Tuesday, January 1, at his home. Doctor Adamski graduated from the Marquette University School of Medicine in 1934, and interned at St. Luke's Hospital, Milwaukee, and at Lutheran and Victory Memorial Hospitals in Brooklyn, New York, before establishing a general practice in Racine. He did graduate work in surgery at Cook County Hospital in Chicago.

With connections at both St. Luke's and St. Mary's Hospitals, he also did considerable work for the police and sheriff's departments. An article discussing a simplified transfusion apparatus for infants, written by the doctor, appeared in the September, 1945, *Journal.* Doctor Adamski served as assistant physician and surgeon at Sunnyrest, Racine County Tuberculosis Sanitorium, physician for the Wisconsin Gas and Electric Company in Racine, and physician and surgeon for St. Bonaventure's College for Boys in Sturtevant.

Doctor Adamski was a member of the Racine County Medical Society, the State Medical Society, the American College of Chest Surgeons, and a Fellow in the American Medical Association.

He is survived by his wife.

Dr. Sylvester M. Welsh, 43, former physician at Beaumont Hospital, Prairie du Chien; St. Francis Hospital, La Crosse; and a hospital at Waukesha, died at St. Joseph's Hospital in Milwaukee on Monday, November 26.

Doctor Welsh was graduated from the University of Iowa School of Medicine in 1929. He entered the Army Medical Corps in July, 1941, and was discharged in June, 1942.

His wife and three children survive.

Dr. John C. Wright, residing in Stevens Point since 1928, died in a Madison hospital on Wednesday, November 21. He was 62 years of age.

Doctor Wright was born in Scotland, where he attended school. He practiced in Kaukauna, Brillion, and Appleton until 1929.

Survivors include his wife and son.

Dr. Evert C. Hartman, pediatrics specialist in Janesville since 1928, died Friday, November 30, in a local hospial after a brief illness. He was 63 years of age.

A 1908 graduate of Northwestern University Medical School, Doctor Hartman also studied pediatrics at Washington University in St. Louis, and took postgraduate work at the University of Minnesota and the Children's Memorial Hospital in Chicago.

He practiced medicine for seventeen years in Algona, Iowa, before coming to Janesville, where for the last seventeen years he has been associated with the Pember-Nuzum Clinic. He was a member of the staffs of Mercy Hospital and Pinehurst Sanatorium, and served as a preceptor of the University of Wisconsin Medical School. He was a veteran of World War I.

Doctor Hartman was a member of the Rock County Medical Society, of which he was president, the State Medical Society, the American Trudeau Society, advisory board member of the local branch of the Childrens' Service Society of Wisconsin, and a Fellow in the American Medical Association.

Survivors include his wife, one daughter, and two sons.

Dr. Robert H. Feldt, 36, of Milwaukee, died at a local hospital Monday, October 8.

Doctor Feldt was graduated from Northwestern University Medical School in 1934, and served on the staffs of Milwaukee Children's Hospital and Columbia Hospital. He was an assistant medical director for the Northwestern Mutual Life Insurance Company at the time of his death.

Doctor Feldt was a member of the Medical Society of Milwaukee County, the State Medical Society, and held a fellowship in the American Medical Association.

He is survived by his wife and two sons.

CORRESPONDENCE

December 17, 1945

Editor, Wisconsin Medical Journal
917 Tenney Building
Madison, Wisconsin

Dear Sir: In the December issue there is a short recommendation of a sulpha-calamine lotion to be used in "pruritis and dermatitis where the soothing protective and astringent action of calamine is required."*

I feel that the objection of a dermatologist to this prescription is justified for several reasons.

1. Sulfathiazole is a skin sensitizing agent, the external use of which should be strictly limited to small areas of pyogenic infection. Even there, less sensitizing, and in many cases, just as effective drugs are available. It is not without danger to use a 10% sulfathiazole lotion indiscriminately over large areas of "pruritis and dermatitis."

* Pharmaceutical News for Physicians.
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Sulfathiazole ---------- 9.0 Gm.
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(Continued on page 272)

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MRS. J. S. HUEBNER
Hygeia Chairman

Serving her second term as State Hygeia Chairman, Mrs. Huebner was president of the Fond du Lac Medical Auxiliary in 1943–44.

She is president of the Fond du Lac Branch of the A. A. U. W. During the war she worked for the O. P. A.

It is with pleasure that I take this opportunity to speak to the Auxiliaries of Wisconsin about *Hygeia.* I am sure each *Hygeia* chairman has received the personal letter I sent her in the fall because through that communication I hoped to reach each member of your Auxiliary to talk just about your county and what you have done.

Again, let me remind you of our progress.

In 1943-1944 Wisconsin had 533 subscriptions to Hygeia.

In 1944-1945 Wisconsin had 690 subscriptions. So let us continue our fine work.

Let me give you some facts concerning *Hygeia:*

1. *Hygeia* prints authentic health information.

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5. *Hygeia* teaches how to form health habits intelligently.

6. *Hygeia* serves as a text and reference book.

7. *Hygeia* deals with the simple but fundamental principles of health that affect daily living in homes, schools, and communities.

8. *Hygeia* contains child welfare articles for mothers who are helping their children form health habits.

9. *Hygeia* is the medium of conveying to the people who are not patients of the medical profession, scientific information concerning the prevention of disease.

10. *Hygeia* gives health information but each article emphasizes the intrinsic value of your family physician.

Hygeia is of value to the physician, to the educator, and to the parent.

I. To the Physician

Literature written by scientists in non-technical language is the best method of informing the public about the nostrum evil and the unwise use of so-called "patent medicines," extravagant claims of the conscienceless advertiser, and the farther reaching method of periodic health examinations.

II. To the Educator

Hygeia can be used without hesitance in the study of every phase of health—child training, diet, exercise, and recreation; individual, community, and social health problems; new medical discoveries; and promotion of physical and mental efficiency.

III. To the Parent

It requires intelligence, quick thinking, and infinite patience to satisfy the thirst for knowledge that children possess, but it is a duty that cannot be shirked. It is clear to see that since the schools do not care for the children during the earliest period, this, their first training, is in the hands of the mother or parents. It is wasting precious opportunities to neglect them for the first six years of their lives.

(Continued on page 266)

Satisfactory Menopause Relief

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Hygeia in your Auxiliary

I would like to urge each Auxiliary to plan a *Hygeia* Round Table program before you close your meetings for the summer months.

The Fond du Lac Auxiliary has a program of this nature under way for the latter part of January. The majority of members have been assigned an article from one of the recent issues of *Hygeia*. Each will give the important points from the author of the article and any other contributions from the group on that subject will follow her brief report. We're looking forward to an interesting meeting with much information for all of us as many do not take the time to read all of *Hygeia's* interesting material.

I shall be happy to give any of you the results of our meeting, and, perhaps, how we might have improved upon it.

I hope that as I hear from the *Hygeia* chairmen of Wisconsin, during the month of February, to report your number of subscriptions, that you will include any such plans for a *Hygeia* meeting. Or, if you have had such a meeting this year—what were the results?

With every Auxiliary member in the state working with her county *Hygeia* chairman we hope for the best year in *Hygeia* to date.

MRS. N. A. HILL
Treasurer

State Treasurer of the Woman's Auxiliary since 1943, and a Doctor of Philosophy, Mrs. Hill is a member of Phi Beta Kappa, Sigma Xi, Phi Delta Gamma, Sigma Delta Epsilon (National Secretary for two years), and A. A. U. W.

She has been active in the Nakoma Welfare League as Secretary in Red Cross and War Chest drives. As a Gray Lady she works in the Federal Hospitals at Truax Field and Mendota doing bedside recreational handicraft.

This is a very good time of the year for your Treasurer to remind you that dues are now payable. The County Treasurers have received their instructions and blanks and are ready to send in all dues received by March 1. These in turn are sent to the National Auxiliary. The number of delegates we are allowed at the National Convention is based on our membership. Last year many dues were received too late to be counted. In fact, we had a final total membership of over 1,000 and might have been listed with other states with that number had every county sent in its dues by March 1. It facilitates my work greatly if all dues are received at one time.

The Treasurer's office maintains a file of all members. Changes of address are recorded and a necrology table is kept. The County Treasurers aid in this work and have been most helpful and cooperative.

MRS. J. R. MINAHAN
Corresponding Secretary

Mrs. Minahan was first operating assistant to the late Dr. John R. Minahan at St. Vincent's Hospital, Green Bay, for eleven years.

She has been president of the Brown-Kewaunee-Door County Auxiliary and Chairman of the State Finance Committee. Her other activities include Red Cross work and the Women's Club of Green Bay, of which she has been program chairman for two years.

My first act as corresponding secretary was to inform Mr. Crownhart of the reaction of the State Auxiliary Board meeting in Milwaukee to the proposal to discontinue our column in the Journal and substitute a news letter. The next was to place in the hands of the national secretary, state officers, and twenty presidents the names and addresses of state officers and chairmen of standing committees and to request all county presidents to file names and addresses of their officers and county chairmen with this office and to state the time of the annual meeting.

A request to the State Medical Society office for Auxiliary stationery to be sent to all state chairmen has been made. All communications requiring a reply have been answered.

Auxiliary Proceedings

Brown—Kewaunee—Door

The November meeting of the Brown-Kewaunee-Door County Medical Auxiliary was held Wednesday afternoon, November 28, at the home of Mrs. John R. Minahan. The group held a business meeting and then did some sewing for their philanthropic project, the loan closet, which furnishes articles to be used in the sick room. Mrs. E. S. Schmidt reported that a number of donations of garments and articles have been received for the loan closet.

Dane

The December meeting of the Dane County Medical Auxiliary was held at the home of Mrs. Homer M. Carter Monday afternoon, December 10. Assisting hostesses were Mrs. C. K. Schubert, Mrs. George H. Ewell, Mrs. David L. Williams, and Mrs. J. C. Doolittle. A Christmas program followed the dessert. Mrs. Herman W. Wirka gave a reading. Mrs. Merrill Heffner, soloist, assisted by Mrs. Arthur Hasler, Miss Eleanor Ferguson, Mrs. Ruth Piper Dykman, Mrs. Virginia Loveland, and Mrs. Mary Alverson sang Christmas songs. They were accompanied by Mrs. Chester Easum.

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Mrs. Thomas W. Tormey, Jr., was hostess to the Dane County Medical Auxiliary Monday, January 14, at her home, 1 North Prospect Avenue, Madison. The members enjoyed a dessert bridge. Mrs. Donald Britton was general chairman. The winners at bridge were Mrs. Homer Carter, Mrs. John G. Van Gemert, and Mrs. C. K. Schubert. Mrs. Claude Schroeder won the door prize.

Fond du Lac

The Auxiliary to the Fond du Lac County Medical Society held a joint meeting with the Medical Society Thursday, November 15. The Auxiliary meeting was held following dinner at the Elks Club. Eighteen members were present.

After routine business the members decided to devote the next meeting to talks on items from Hygeia, and to hearing a report of the State Medical Society meeting. Mrs. Eliya Connell, Mrs. Joseph C. Devine, and Mrs. John C. Yockey were appointed to have charge of the meeting.

Plans were made to adopt an unfortunate family for Christmas and Mrs. David Twohig was appointed chairman of the committee with Mrs. Stephen Theisen, Mrs. Hubert A. Devine, and Mrs. Jewel Huebner assisting.

After the meeting the women joined their husbands and heard a talk by Dr. J. S. Wier on his experiences in the European theatre of war.

Kenosha

At the home of Mrs. Leslie Kent on January 10, the Kenosha County Medical Auxiliary heard Thomas Kennedy, local druggist, discuss "Pharmaceutical Horizons." Mrs. A. F. Ruffio, the new president, presided at the business meeting, during which Mrs. Leif Lokvam reported on the circulation of Hygeia through the county. The Auxiliary plans to donate a copy of the magazine to each of the county schools. Mrs. L. E. Coffin presided during the refreshment hour.

La Crosse

The Woman's Auxiliary to the La Crosse County Medical Society held an open dinner meeting Tuesday, January 8, at the Hotel Stoddard. The speaker was Dr. Walter J. Meek of the physiology department of the University of Wisconsin, who spoke on "Animal Experimentation." Men and women of the city were invited to hear him. Mrs. Robert Flynn was chairman for the evening.

Milwaukee

The Woman's Auxiliary to the Milwaukee County Medical Society met Friday, December 14, at the City Club. The group was led in community singing, following luncheon, by James Robertson of radio station WTMJ. Mrs. Arthur McCarey of Green Bay was guest of honor. The speaker was Colonel John Beffel, veteran of overseas service with the Medical Corps, who spoke on "Through Italy and Africa with an Evacuation Hospital."

The Woman's Auxiliary to the Milwaukee County Medical Society held its first meeting of the year Friday, January 11, at the Hotel Schroeder. Luncheon was served after which Mrs. Frederick Lindley reviewed "Where Do People Take Their Troubles." The author of the book, Lee R. Steiner, was given the assignment to write this work, following a long period of research, by the Illinois Society for Mental Hygiene. It is an eye-opening study of cults and quackery. R. S. Saylor spoke briefly on "Surgical Care and the Blue Cross."

Sheboygan

Mrs. Friedrich Eigenberger was the guest speaker at the Sheboygan County Auxiliary when it met November 14 at the home of Mrs. William G. Meier, 210 Superior Avenue. Mrs. Eigenberger spoke on searching for orchids in the Mexican jungles, and of having obtained rare and unusual specimens of other plants as well as orchids. The talk was illustrated by photographs and Mexican music was played.

Gifts to be sent to the veterans at Wood were brought to the meeting.

The Auxiliary to the Sheboygan County Medical Society held a luncheon meeting December 17 at the Hotel Curtiss, Plymouth. John Shavlen, a veteran of two years' service, gave an interesting talk on India. He discussed the people, the caste system, their dress and customs, and the attitude of the Indian towards the British rule. There was a short business meeting following the speaker.

Miss Theresa Sam Martin was guest speaker at the January meeting of the Woman's Auxiliary to the Sheboygan County Medical Society. The speaker, a laboratory technician at Sheboygan Memorial Hospital, discussed customs, education, and the people of her native country, Peru. The meeting was held at the Hotel Foeste.

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Washington—Ozaukee

The Washington-Ozaukee Medical Auxiliary met at the Cedars in Cedarburg November 15 for a one o'clock luncheon. Mrs. K. T. Bauer of West Bend presided. Subscriptions to Hygeia and donations to veterans at Wood were discussed. It was decided that each member should bring a gift to the December 13 meeting at West Bend. Articles suggested were wash cloths, tooth brushes, playing cards, and cigarettes.

Waukesha

The Woman's Auxiliary to the Waukesha County Medical Society met at the Women's Club, Waukesha, Wednesday, December 4, at 2:30 p. m. The Waukesha County Council of Child Welfare were special guests of the Auxiliary and there were approximately fifty members and guests in attendance.

Miss Hertha Voje, president, presided and introduced the speaker, Dr. Esther E. de Weerdt, Executive Director of the Wisconsin Society for Mental Health. She discussed the topic, "The Home and Community and the Convalescent from Mental Illness."

Doctor de Weerdt's talk concerned especially the returning soldiers and she listed three sources from which the cases developed: (1) rejection of inductees; (2) returned trainees; (3) those broken in combat. Three suggestions were charted for guidance: (1) Mental illness is no disgrace and not the ogre we were formerly led to believe. (2) We must plan for recovery. (3) Approach the problem with hope just as in any other illness. Doctor de Weerdt invited discussion from the audience and several commented on various phases of the subject. Following her talk she was asked to comment on juvenile delinquency and responded with several interesting incidences in her experience.

Mrs. Gordon Brewer, Hartland, who was elected president-elect in October, has resigned because she will be out of the county for some time. Mrs. William H. Oatway, Waukesha, has been nominated to fill the vacancy and will carry on in Mrs. Brewer's place.

Mrs. Andrew J. Loughnan, Oconomowoc, philanthropic chairman, is carrying on our annual project of gifts for the boys at the Wisconsin Home and Farm School at Dousman. Mrs. James Hassall, Oconomowoc, Hygeia chairman, is renewing the Hygeia subscriptions and securing new ones.

We are especially happy to welcome back to our community a number of our former auxiliary members whose husbands have been discharged from service, and we hope to once again operate on a normal schedule.

We have voted to hold only three meetings this year and our next meeting will be held in June.

The Waukesha members were hostesses at tea following this meeting, December 5.

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(Continued from page 220)

method. It can, for instance, show that in England, where medically sponsored voluntary plans exist side by side with the government compulsory system, the administration cost of the former takes only about 20 per cent of subscribers' premiums, leaving 80 per cent for medical care, whereas in the government insurance fund 84 per cent must be set aside for "administrative overhead," leaving only 16 per cent for the actual payment of medical costs.

But the alternative is no longer between a compulsory plan and no plan at all. Voluntary insurance is the only alternative. And the number of subscribers to voluntary plans must be rapidly increased from the present total of approximately two million if the alternative is to be effective. Hence, we in the College applaud the doctors of Wisconsin and the other twenty states where medical insurance under medical control has been made available.—MAC F. CAHAL, Chicago.

CORRESPONDENCE

(Continued from page 262)

2. Sulfathiazole itself has no "soothing protective and astringent action."

3. Calamine lotion has some soothing and protective, but no astringent action. Therefore, calamine lotion alone is not objectional. However, there are better antipruritic remedies, the choice of which depends much on the case.

4. It is misleading to emphasize any special effect of calamine. Calamine is nothing but zinc oxide with some degree of impurity caused by iron oxide giving it the pink color which, however, is not heavy enough to match the skin. Calamine as a drug, therefore, is superfluous.

5. The spelling "pruritis" should not be used. In analogy to other words with the suffix "itis," it would mean the inflammation of an itching which, of course, is nonsensical. The correct spelling is *pruritus* which in the present dermatological usage means just the symptom of itching without any implication regarding the cause.

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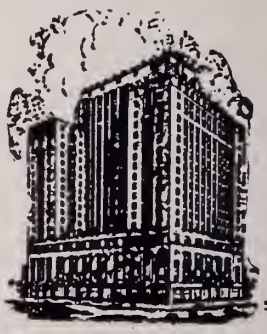

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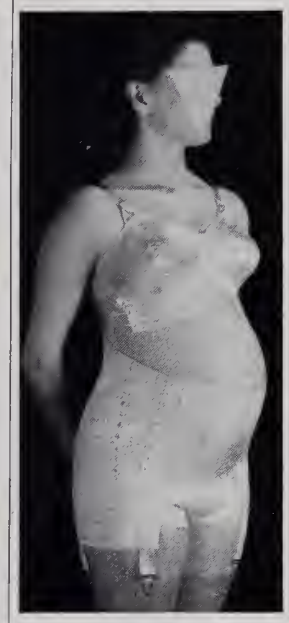

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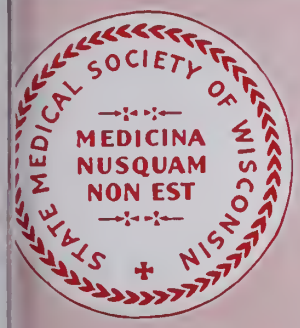

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IN THIS ISSUE

CLINICAL EXAMINATION OF THE CEREBROSPINAL FLUID—AN OUTLINE
By H. Houston Merritt, M. D., and Charles Brenner, M. D.

COMMENTS ON TREATMENT

NOTES ON CLINICAL PATHOLOGY

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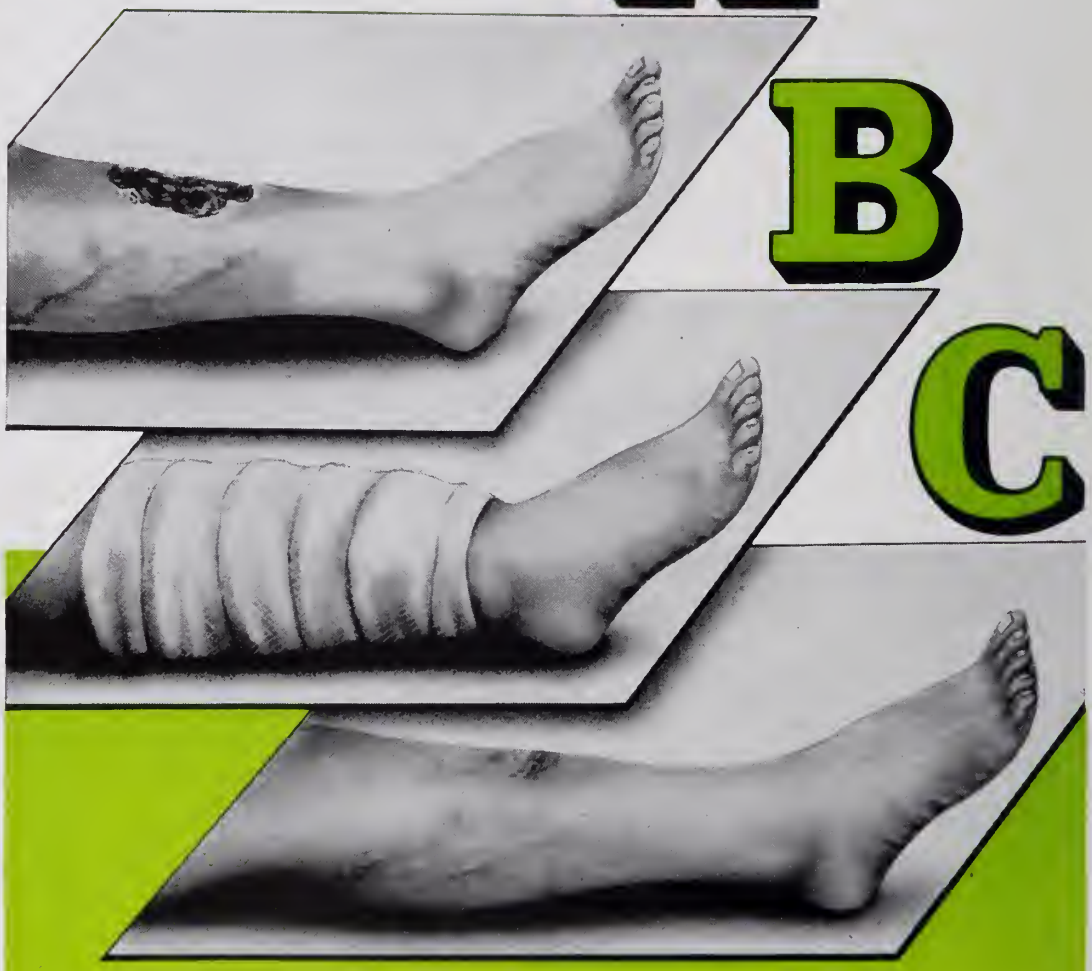

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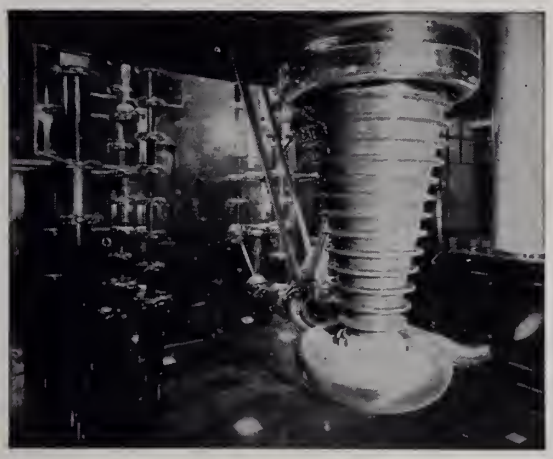

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*Anderson, Geo. K., M.D.: *The Importance of Protein in Diet Therapy,* J. Am. Dietet. A. 21:436 (July-August) 1945.

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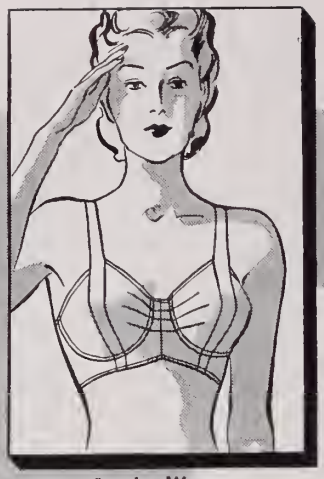

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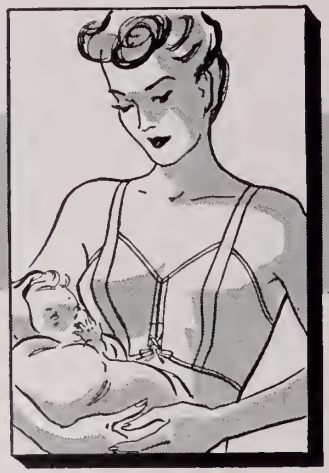

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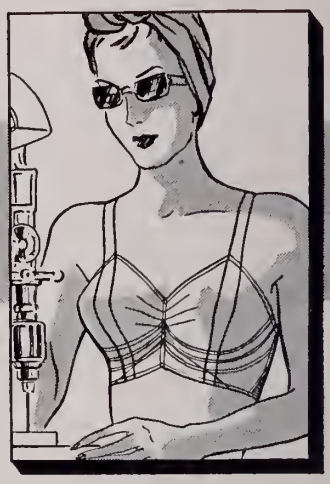

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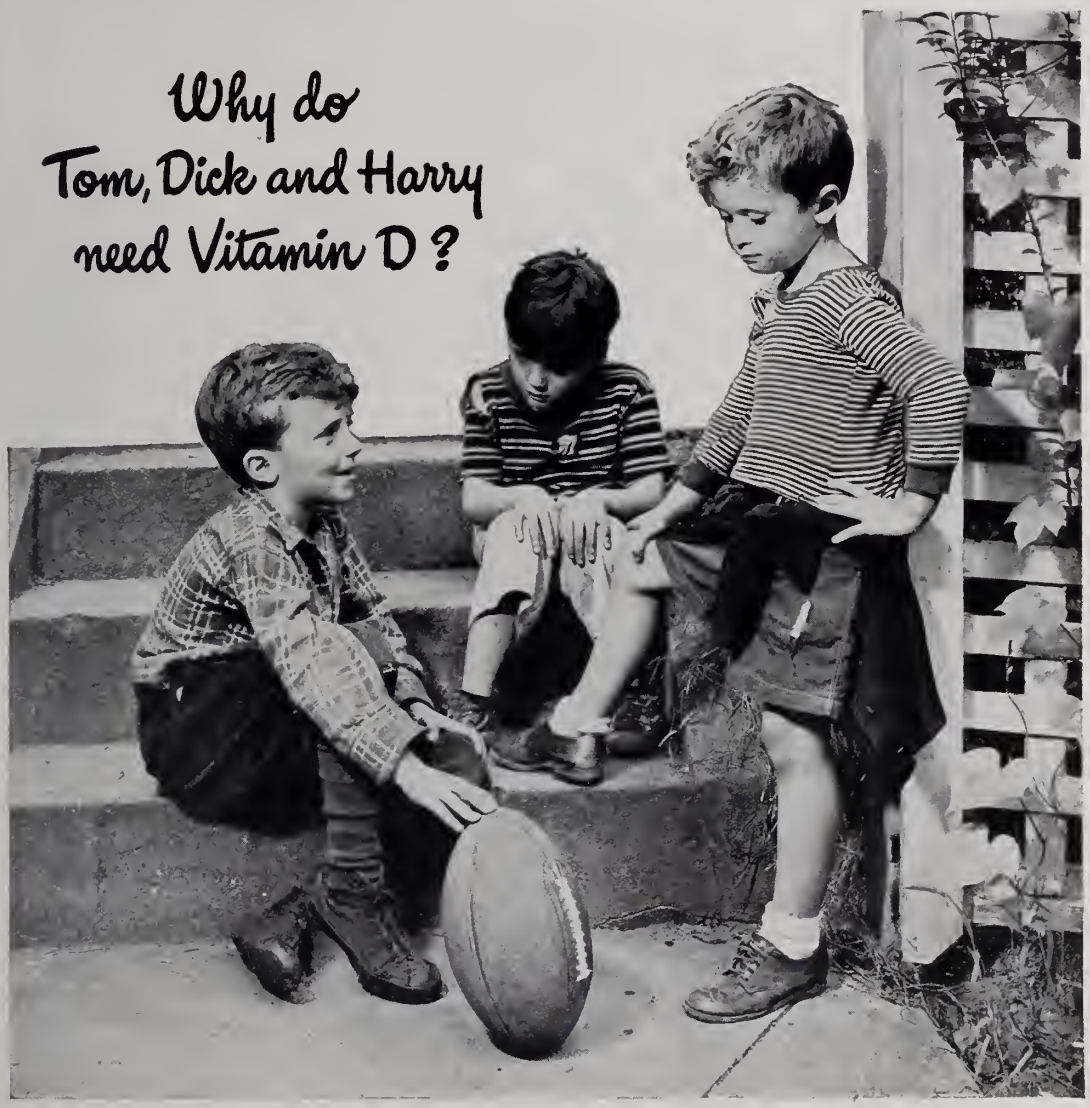

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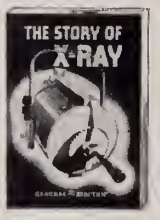

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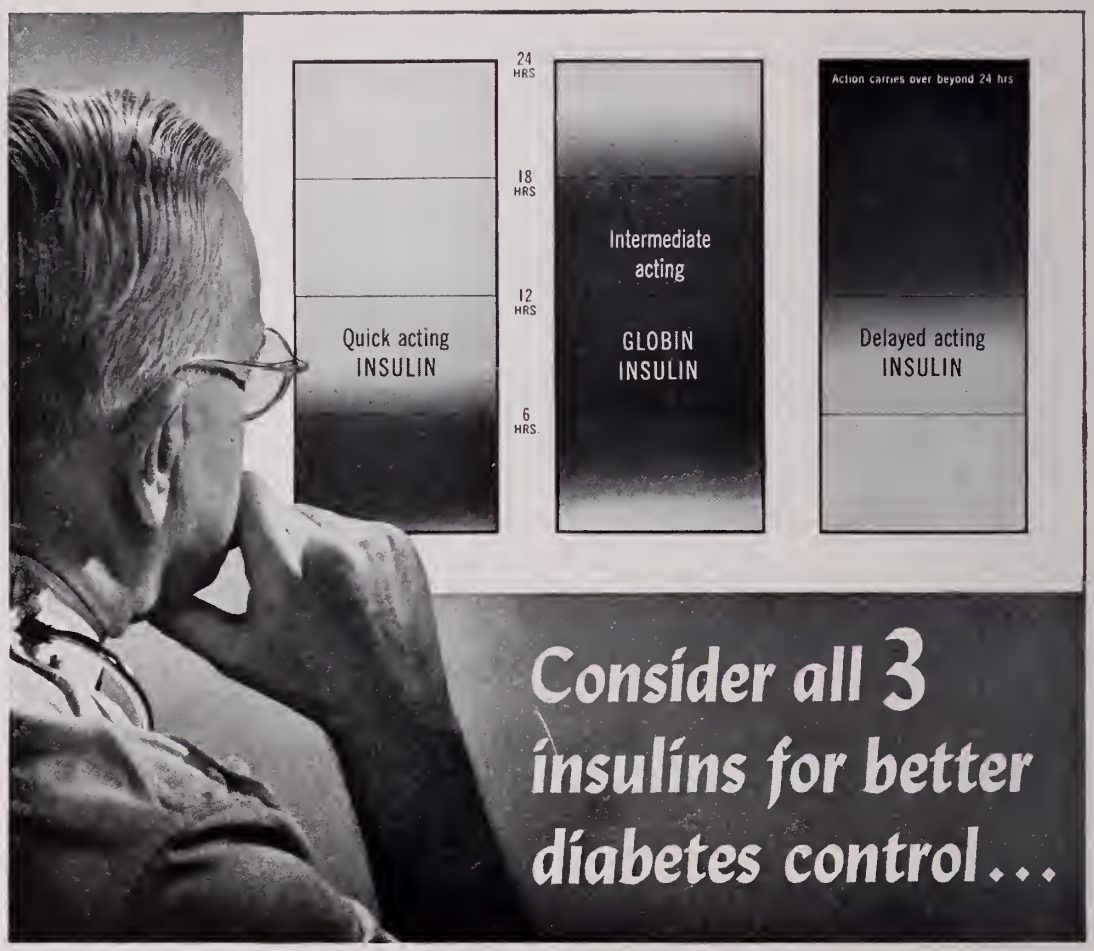

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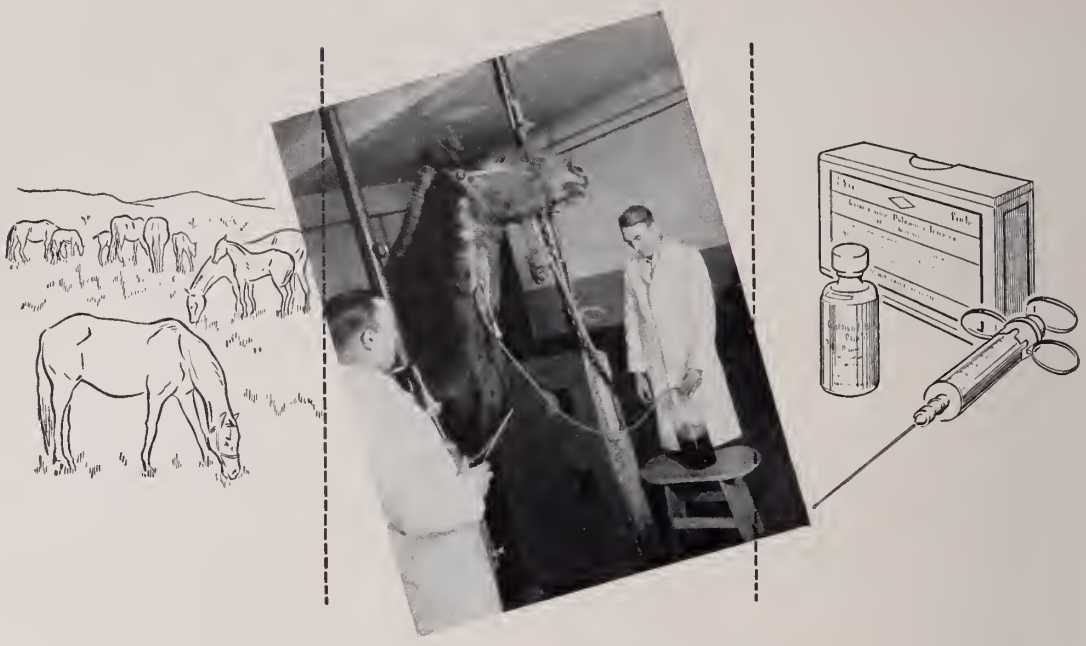

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Clinical Examination of the Cerebrospinal Fluid

AN OUTLINE

By H. HOUSTON MERRITT, M. D. and CHARLES BRENNER, M. D.*

New York

H. HOUSTON MERRITT

A 1926 graduate of Johns Hopkins Medical School, Doctor Merritt was a national research fellow at Deutsche Forschungsanstalt in Munich.

Doctor Merritt is now professor of clinical neurology at the College of Physicians and Surgeons, Columbia University and chief of the division of neuropsychiatry, Montefiore Hospital.

CHARLES BRENNER

Doctor Brenner graduated from Harvard Medical School in 1935. He was formerly assistant in neurology and junior visiting neurologist at Boston City Hospital.

Doctor Brenner is now assistant in neurology of the College of Physicians and Surgeons at Columbia University and associate attending physician with the division of neuropsychiatry at Montefiore Hospital.

EXAMINATION of the cerebrospinal fluid is the most valuable of all the special diagnostic procedures available in the study of the patient suspected of disease of the nervous system. The fluid is easy to obtain; the methods of its examination are well standardized; and their results are almost always of the greatest importance in reaching a correct diagnosis. It is, therefore, essential that the physician who treats such patients have a good working knowledge of what the results of examination of the cerebrospinal fluid mean: what are normal and what abnormal, what pathologic processes or diseases are suggested by the various abnormalities commonly found, and equally important, what ones are excluded by the absence of abnormal findings.

It is important that the operator, before making a lumbar puncture, have a clear conception of how the examination of the cerebrospinal fluid can help in the diagnosis (or treatment) of the case under consideration, and exactly which tests should be performed to gain the desired information. For example, it is of vital importance to test the dynamics of the cerebrospinal fluid circulation by abdominal and jugular compression in patients with signs and symptoms indicating a lesion in the spinal cord. On the other hand, exact measurement of the intracranial pressure is of importance in patients with a clinical picture indicating a lesion of the brain but the dynamics are relatively unimportant in many such cases and compression of the jugular veins is inadvisable when the intracranial pressure is high. It is wise, however, to perform all examinations that may give some valuable information. This will obviate the need of a repeat puncture to get some information which is of importance but which was not obtained by the first puncture. The minimum routine for the initial examination should include: (1) measurement of pressure, (2) testing of dynamics

* Division of Neuropsychiatry, Montefiore Hospital and Department of Neurology College of Physicians and Surgeons, Columbia University, New York.

(except as noted above), (3) inspection of fluid, (4) cell count, (5) estimation of protein content (qualitative and quantitative), (6) colloidal test, and (7) specific tests for syphilis. If an infection of the nervous system is suspected or if the fluid is turbid or contains more than 10 cells per cu. mm., the initial examination should include: (8) bacteriologic examinations (stained smears and culture on suitable medium), and (9) determination of the glucose and chloride content of the fluid.

On repeat examinations of the fluid the tests which will not yield information of value in the case under consideration can be omitted. For example, it would not be necessary to repeat colloid tests and specific tests for syphilis on the fluids of patients who are under treatment for meningococcus meningitis.

It is the aim of this manual to furnish the basis for a working knowledge of the cerebrospinal fluid in health and in disease, in compact and convenient form to the general practitioner. There has been no attempt at completeness and those who are interested in a more detailed discussion of the subject are referred to the text of Merritt and Fremont–Smith.[1] We have tried to present the most important facts clearly, accurately, and simply with a minimum of discussion and qualification.

General Considerations

The exact origin and nature of the cerebrospinal fluid have long been matters of debate. The generally accepted opinion at present is that it is formed by the choroid plexuses in the cerebral ventricles, i.e., the cerebrospinal fluid is a choroidal "filtrate" in the same sense that urine (before passing through the renal tubules) is a glomerular filtrate. The fluid thus formed passes from the lateral ventricles into the third ventricle, through the cerebral aqueduct to the fourth ventricle and then out the foramen of Luschka into the subarachnoid space (basal cistern). Thence it passes down over the cord all the way to the lumbar sac or forward over the cerebellum and under the tentorium up over the cerebral hemispheres. It is eventually reabsorbed into the venous circulation through the Pacchionian villi in the large dural sinuses. Thus the cerebrospinal fluid is contained in the intraventricular and subarachnoid spaces and is probably in communication with the pericellular spaces by way of the perivascular spaces. It is, therefore, in intimate contact with the inner and outer surfaces of the brain as well as with the spinal and cerebral meninges. It is as a result of this close contact that inflammatory processes in the meninges or parenchyma of the central nervous system itself produce detectable changes in the cerebrospinal fluid.

An anatomic consideration of practical importance is that the cranial and spinal dura form the wall of a single cavity which, though not rigid, is relatively inelastic. That is, it may be compressed from without but cannot normally be distended by pressure from within, largely because of the resistance of the dura mater and the bony structures around it. Within this cavity are the brain and spinal cord, blood vessels, and cerebrospinal fluid. A moment's consideration will show that the only one of these elements which is quickly and readily compressible is the vascular one and in particular the large veins: inside the skull the dural sinuses, which drain into the internal jugular vein, and in the spinal canal the dural plexuses, which drain into the great veins of the abdomen.

The important consequence of these facts is that there is a direct relationship between systemic venous pressure and intradural pressure as measured for example with a spinal fluid manometer by lumbar puncture. Any procedure which raises the venous pressure will correspondingly raise the cerebrospinal fluid pressure and any procedure which lowers venous pressure will lower cerebrospinal fluid pressure. The practical significance of this relationship will be discussed in a later section. It may be added that the converse of the relationship is not true, i.e., an increase (or decrease) in cerebrospinal fluid pressure does not cause an increase (or decrease) in systemic venous pressure.

Technic of Obtaining Fluid

Indications—Lumbar puncture is indicated in any case with symptoms and signs of meningeal irritation, and in all cases where the cerebrospinal fluid findings will be of aid in the diagnosis or treatment of the case. Lumbar puncture is especially valuable in: (1) the diagnosis and treatment of acute or chronic inflammations of the meninges, (2) the diagnosis and treatment of meningism, (3) diagnosis and treatment of head injuries, (4) the diagnosis of diseases of the central nervous system in which the clinical signs and symptoms are not diagnostic, and (5) the intelligent treatment of syphilis. The status of the cerebrospinal fluid in every patient with syphilis should be known by the physician treating the case.

Contraindications—Lumbar puncture is contraindicated in cases where it would be necessary to puncture through infected skin or subcutaneous tissues. Puncture is often necessary to establish the diagnosis of spinal epidural abscess, and it can be safely performed if the stylet is withdrawn and the needle is aspirated by syringe as the epidural space is approached. If pus is encountered, the needle is withdrawn without puncturing the subarachnoid space.

Puncture is contraindicated in any case where the diagnosis is obvious and no additional information in regard to the treatment of the case will be obtained by the puncture. This is especially applicable in cases with tumors of the brain with high-grade choked discs. There are, however, many cases with signs and symptoms suggestive of an expanding intracranial lesion in which a lumbar puncture is absolutely necessary for the proper diagnosis. The findings at lumbar puncture have obviated needless craniotomies in many cases.

Detailed instructions for routine lumbar or cisternal puncture are readily available and will not be repeated here. In our experience the most convenient type of needle to use when cerebrospinal fluid pressure is to be measured has been that devised by Ayer and Fremont–Smith in which the three-way stopcock is soldered into the butt of the needle and the stylet is made to fit through both stopcock and needle proper. For adequate measurement of pressure changes on jugular or abdominal compression the needle should be at least 20 gauge and preferably 19. It should be remembered, however, that the larger the diameter of the needle the larger the tear it makes in the dura and the more likely the patient is to have post lumbar puncture headache. For this reason one should use the finest needle available for patients in whom pressure measurements are of no importance and may be omitted, as for example in routine punctures on syphilitic patients or punctures for spinal anesthesia.

In doing lumbar punctures on infants it is important to remember that the spinal cord extends more nearly the entire length of the bony spine than in later years. An ordinary intravenous needle is quite satisfactory and in very young infants the needle passes almost as easily through a spinous process as through the connective tissue between the spines.

Cisternal puncture is safe and simple when done by an expert, but potentially dangerous when done by a novice. Spinal puncture in the thoracic region is also not to be recommended to the novice. Ventricular puncture is generally a surgical procedure.

Fluid is most conveniently collected in three clean (preferably sterilized) test tubes. The first tube should contain about 1 cc. for cell count, Pandy and ammonium sulphate tests; the second tube, 4–8 cc. for the various chemical analyses and the colloidal gold test; and the final tube, 4–6 cc. for complement fixation or precipitin tests. The three tube method also helps to distinguish a bloody tap from pathologic subarachnoid bleeding. In the case of a bloody tap there will be more blood in the first tube than in the second or third because of dilution as clear fluid flows down from above. If blood was already in the cerebrospinal fluid before the puncture, the fluid will be equally bloody in all three tubes, or occasionally bloodier in the last than the first.

If the initial pressure is very high (above 350 mm.) and in any case if one suspects the presence of a subtentorial tumor, fluid should be removed very slowly (1 drop a second or less) and the pressure should not be

reduced too much by the puncture. The usual rule is that the final pressure should be at least one half the initial pressure.

Results

As outlined above, the standard data which one expects from examination of the cerebrospinal fluid are these: initial pressure, color and clarity of the fluid, number and types of cells per cu. mm., protein content of fluid, either exact (mg. per 100 cc.) or approximate (Pandy and ammonium sulphate tests), colloidal reaction, and Wassermann reaction (or other tests for syphilis).

Additional data frequently valuable are: response of cerebrospinal fluid pressure to jugular and abdominal compression, sugar content of fluid (mg. per 100 cc.), chloride content of fluid (usually expressed either as mg. of sodium chloride per 100 cc., or milliequivalents per 1,000 cc.), and bacteriologic studies, such as culture, guinea pig inoculation, etc.

The significance and interpretation of each of these results will be discussed briefly before passing on to the consideration of the cerebrospinal fluid syndromes characteristic of various disease processes.

Pressure

The normal range of values for cerebrospinal fluid pressure in adults is 80 to 160 mm. of cerebrospinal fluid. Pressures above 200 mm. are definitely abnormal, while those between 160 and 200 mm. are suggestively high.

A common cause of high initial pressure is inadequate relaxation on the part of the patient. The only satisfactory way to overcome this is by reassuring the patient, making him as comfortable as possible, and if necessary, waiting 5–15 minutes for him to relax. Having the patient breathe deeply 8–10 times with his mouth open may assist in obtaining relaxation but it must be remembered that this procedure lowers systemic venous pressure and hence produces an artificially *low* cerebrospinal fluid pressure.

If the cerebrospinal pressure is found to be elevated despite adequate relaxation there is a variety of possible causes which must be considered. Variations in venous pressure are reflected in cerebrospinal fluid pressure. A striking illustration of this can be noted by compressing the jugular veins which causes an increase in venous pressure in the head and a rapid rise in the cerebrospinal fluid pressure. This compression of the jugular veins is used clinically to test the free communication between the fluid in the ventricles and that in the subarachnoid space. Failure of transmission of this increase in pressure to the fluid in the lumbar sac is evidence of block in the cerebrospinal fluid circulation. This test is of special value in patients where the diagnosis of spinal cord neoplasm is suspected. Alterations in osmotic pressure of the plasma will produce changes in the cerebrospinal fluid pressure. A clinical application of this fact is the use of hypertonic solutions intravenously to reduce intracranial pressure. Conversely, if hypotonic solutions are given intravenously, the cerebrospinal fluid pressure will rise. Such a situation occurs clinically in the syndrome of meningism, which is seen commonly in children at the onset of infections. At the onset of acute infections there is a retention of body fluids with a reduction in the osmotic pressure of the serum which is sometimes so severe that the resultant rise in intracranial pressure is accompanied by stiffness of the neck, headache, and even coma. In such cases the cerebrospinal fluid is under increased pressure but is otherwise normal except for slight decrease in the protein and chloride content. Alterations in intracanial pressure can be produced by any factor that affects the filtration pressure in the capillaries of the choroid plexus. Capillary pressure is directly related to venous pressure and has no relationship to arterial pressure. For this reason the cerebrospinal fluid pressure is usually normal in patients with hypertension. On the other hand, any factor which produces a rise in venous pressure will cause an increase in the cerebrospinal fluid pressure. Illustration of jugular compression has been given. In addition, any neoplasm that presses on the large venous trunks or sinuses in the thorax or head will act in a similar manner. The spinal fluid pressure may be increased by the presence of any foreign substance in the semi-rigid cranial cavity, such as extravasated blood, pus, or a

new-growth. Tumors of the brain not only affect the intracranial pressure by their bulk but also may press on venous channels and cause a rise in venous pressure. Intracranial pressure can be increased by any mechanism which interferes with the free flow of the fluid from the ventricular spaces to the subarachnoid space or that interferes with the absorption of the fluid from the subarachnoid space into the dural sinuses. Blocking of these communications produces internal hydrocephalus.

Hydrocephalus is usually divided into two classes, communicating and noncommunicating. In the communicating type there is a free flow of fluid through all of the channels within the brain and between the fourth ventricle and subarachnoid space, but there is a defect in the absorption mechanism due either to aplasia of the arachnoid villi or to occlusion of these villi by inflammatory exudate. In the non-communicating type of hydrocephalus, the fluid is confined within the ventricular cavities of the brain; unilateral hydrocephalus can develop from occlusion of the foramen of Munro by exudate or tumor, and bilateral hydrocephalus by similar occlusion of the third ventricle, aqueduct of Sylvius, fourth ventricle, or of the foramina of escape of the fluid from the fourth ventricle. With the exception of tumors and the rare cases of occlusion of the aqueduct of Sylvius or foramina of Luschka by exudate, the majority of the cases of hydrocephalus are of the communicating type. In most instances there is some absorption of cerebrospinal fluid but the rate of absorption is not fast enough to take care of the amount formed.

It is important to remember that none of the conditions and diseases just mentioned, with the single exception of elevated systemic venous pressure, can be excluded from the differential diagnosis if the cerebrospinal fluid pressure is normal. Tumors, abscesses, hematomas, meningitis may all be present with normal cerebrospinal fluid pressure. An elevated cerebrospinal fluid pressure may be good evidence in favor of one of these diagnoses, but a normal pressure does not necessarily exclude any of them.

Color and Clarity

Cerebrospinal fluid is normally water white. A yellow color (xanthochromic) is usually due to degradation products of hemoglobin (changed blood) but may be due to increased protein content of the cerebrospinal fluid as a result of inflammatory processes of various kinds. It is also commonly seen in fluids with high protein content from below a complete spinal block.

A bloody color indicates ventricular or subarachnoid bleeding, either pathologic or as a result of the puncture (blood tap). In a case of spontaneous, intracranial, subarachnoid bleeding the lumbar fluid may be clear for 1–2 hours after the onset of bleeding, but will be uniformly bloody thereafter.

Cloudiness of the cerebrospinal fluid of various degrees up to frank purulence is due to the presence of pus cells. Small numbers of red blood cells make the fluid hazy or opalescent. Very rarely cloudiness is caused by the presence of a large number of bacteria.

Cellular Content

Normally the cerebrospinal fluid contains no red cells and fewer than five white cells per cu. mm. The significance of red cells in the cerebrospinal fluid has just been noted. It should be remembered that a cerebral hemorrhage of the usual spontaneous type associated with hypertension is usually associated with blood in the cerebrospinal fluid because the hemorrhage has ruptured into the subarachnoid space or into a ventricle.

An increased number of white cells in the cerebrospinal fluid (5 or more per cu. mm.) is a sign of inflammation (not necessarily infection) close to the subarachnoid space or the ventricular walls. A large number of cells with a high percentage of polymorphonuclear leukocytes indicates an acute (and usually widespread) inflammation close to or involving the meninges or ependyma; while a small number, most of which are lymphocytes, speaks for a chronic process or one relatively far from meninges and ependyma. The inflammation may be associated with bacterial, virus, or parasitic infection of the parenchyma, meninges, dural sinuses, or bone or it may rarely be caused

by a tumor, vascular occlusion, or degenerative process of obscure etiology.

One must also remember that meningeal inflammation regularly results from the introduction of foreign substances, the most common of which are blood and air. An abnormally high number of white cells in the cerebrospinal fluid at any time within a week after subarachnoid or ventricular bleeding from whatever cause or within a like period after the artificial introduction of air, serum, or chemicals is not a sign of infection of the meninges.

If an accurate differential cell count is desired, a smear must be made and stained with Wright's stain. Accurate identification of a cell as lymphocyte or polymorphonuclear in the counting chamber can be made only by an experienced cytologist.

Protein Content

Normally the protein content of the lumbar fluid varies between 20 and 45 mg. per 100 cc. and that of the cistern fluid between 10 and 25 mg. The ventricular fluid has practically no protein (0 to 5 mg.), and the protein in the cistern and lumbar fluid is probably due to admixture with fluid from the perivascular spaces.

Abnormal Levels—Increase in the protein content usually accompanies any increase in the cells. Inflammatory processes are accompanied by an increased permeability of the blood vessels and a rise in the protein content of the fluid. Degenerative processes do not, as a rule, cause much of an increase in the cerebrospinal fluid protein, but occasionally values between 45 and 75 mg. may occur. High protein content is common with tumors of the brain or spinal cord.

With tumors of the spinal cord the increase in protein is due to two factors: (1) stagnation of the fluid below the level of the block when block is present, and (2) transudation of serum from vessels in or near the tumor. Very high values, 3,000 to 5,000 mg. per 100 cc. are sometimes encountered in such cases. Tumors of the brain may be associated with increased protein content in the fluid with values sometimes as high as several hundred milligrams. The exact mechanism of the increased protein in the fluid of brain tumors is not known. Possibly the same factors that act in spinal cord tumors also play a role here, but there are other factors. High protein content may be found in the absence of inflammatory reaction or tumors in cases of polyneuritis from any cause; especially high values are apt to be common in the so-called "infectious polyneuritis" (polyneuritis with facial diplegia) and diabetic polyneuritis.

Colloidal Tests

Many colloidal tests have been applied to the cerebrospinal fluid, including colloidal benzoin, mastic, ink, and gold. The latter test is most commonly used in this country, and our remarks apply chiefly to this test.

Colloidal Gold Test—Precipitation of the colloidal suspension is related to the electrical charge on the proteins contained in the cerebrospinal fluid. The exact mechanism of the precipitation of the suspension is not known, but it has been shown that the globulin fraction of the protein tends to cause a precipitation of the gold, and the albumin fraction acts to keep it in suspension. Thus, fluids with a decrease in the albumin-globulin ratio often cause precipitation of the suspension. This is not always true, and there probably is in addition some abnormal quality to the globulin which causes precipitation of the colloid.

Grading—In the performance of the test, cerebrospinal fluid is mixed with normal saline in ten tubes with dilutions of the fluid varying from 1:10 to 1:5120. Equal amounts of the colloidal gold suspension are added to each test tube and allowed to stand overnight. The test is read the next morning and changes in the solution are graded from 5 to 0, as follows: 5, complete precipitation of the colloidal gold with decolorization of the supernatant fluid; 4, partial precipitation of the gold and partial decolorization of the solution; 3, a change in color of the solution to violet; 2, a change in color of the solution to lilac; 1, a very slight change in the normal red color of the fluid; 0, no change. Changes which are graded as 1 or 2 are usually of no pathologic significance, but a grade of 3 or greater always means an abnormal fluid.

Abnormal Reactions—The majority of abnormal reactions are in fluids with a high

protein content, but an abnormal reaction may occur in a fluid with a normal total protein, particularly if there is a disturbance of the albumin-globulin ratio. This is especially apt to be found in syphilis of the nervous system and in multiple sclerosis.

First-Zone Curve—The reactions that are found in the cerebrospinal fluid commonly take one of three forms. In the first the greatest change is in the tubes with the highest concentration of the cerebrospinal fluid. Complete precipitation and decolorization is most apt to occur in this type of reaction with readings (curves) as follows: 5555443211, or 5543321100, or 4433221000. This type of curve is spoken of as the "first zone" or "paretic" curve; it is best to avoid the use of the term "paretic" curve because of its prejudicial significance. While this type of curve is found almost constantly in patients with dementia paralytica, it is also quite common in other types of syphilis of the nervous system and in nonsyphilitic disease such as multiple sclerosis and acute encephalomyelitis. It is also occasionally seen in patients with brain abscess, brain tumors, polyneuritis, cerebral hemorrhage, etc.

Mid-Zone Curve—The second type of curve is characterized by the most marked change occurring in the third to sixth tubes. Complete decolorization is rare, and examples of such curves are 1244332100 or 1233321000. This is called the "mid-zone" curve. It was formerly called the "tabetic" curve, but this term has been discarded. This type of curve may be found in any abnormal fluid and is not diagnostic of any disease.

End-Zone Curve—The third type of reaction is one in which the most color change occurs in the tubes with the least concentration of cerebrospinal fluid. This is called the "end-zone" curve. Examples are 0011233333 or 0001223444. This type of curve is most common in fluids with a very high protein content.

Specific Tests For Syphilis

All of the tests for syphilis that have been applied to the blood have been used with modifications in the cerebrospinal fluid. In general the tests are divided in two types: the complement fixation tests and precipitin tests. There is little choice between the two.

A positive reaction in the cerebrospinal fluid when laboratory errors are excluded is diagnostic of syphilis of the nervous system.* There are a few exceptions; for example, if, in a patient with a positive blood Wassermann reaction, a large amount of protein gains access to the cerebrospinal fluid, such as might occur in cerebral hemorrhage, bloody taps, etc., the specific reagin that is present in the serum is admixed with the cerebrospinal fluid and may give a positive test. In such cases, it is necessary to repeat the test when the blood has disappeared from the fluid.

Titration of the complement fixation or precipitin reactions is of value in the diagnosis and treatment of syphilis of the nervous system. While the strength of the reaction cannot be used as a slide rule in the diagnosis, a strongly positive reaction in a small amount of fluid is usually indicative of serious involvement of the nervous system, and favorable results from treatment will not be quickly obtained; for example, in dementia paralytica and early tabes dorsalis the fluid is usually positive even in dilutions of 0.05 cc., and many years of treatment are usually necessary to reverse the reaction.

Dynamics

When the initial pressure has been recorded, the free communication between intracranial fluid and the fluid in the manometer should be demonstrated to give assurance that the pressure recorded in the lumbar manometer is a true measure of intracranial pressure. This requires the help of an experienced assistant, especially in cases where compression of the spinal cord is suspected. In testing the dynamics it must first be determined that the point of the needle is free in the subarachnoid space and not obstructed by a nerve root or a film of arachnoid. A prompt rise and fall in the pressure on pressing on the abdomen with the palm of the hand, or when the patient makes a straining effort, as in defecating, proves free communication between the fluid in the manometer and that in the lumbar

* Positive reactions in the cerebrospinal fluid have been reported in yaws, trypanosomiasis, and cerebral malaria.

sac. This is also indicated by normal pulse and respiratory oscillations.

Testing Jugular Compression—Jugular compression should then be tested by gently placing the fingers on both sides of the patient's neck and compressing the internal jugular veins. The pressure should be great enough to collapse the veins, but not enough to compress the carotid artery or to interfere with respirations. The patient should be cautioned against holding the breath or becoming tense during this procedure. Normally on compressing the jugular veins for ten seconds, there is an increase of 150 to 300 mm. in the pressure, depending on the efficiency of the compression of the veins. On releasing the compression, the pressure should fall to or within a few millimeters of the original level within ten seconds. This should be repeated several times if necessary until the operator is satisfied that the dynamics are free or that dynamic block is present. In doubtful cases the patient should be allowed to inhale amyl nitrite (1 cc.), which causes a dilatation of the cerebral vessels and a prompt rise of the cerebrospinal fluid pressure, except in the cases with block. Graduated compressions by means of a special cuff can be used in special cases.

The variation in the size of the intracranial venous sinuses on the two sides is so great that a comparison of the response obtained by unilateral compression of the jugular veins is of value only in cases with lateral sinus thrombosis.

Evidence of Subarachnoid Block—Subarachnoid block is suggested when jugular compression fails to give a rise in pressure in the lumbar manometer, or when the rise, or particularly when the fall, in pressure on release of the jugular compression is delayed. This suggestive evidence must not be accepted, however, until several confirmatory steps have been taken. In complete or partial block, abdominal compression should give a normal or greater rise than jugular compression. Only with the confirmatory evidence obtained by abdominal compression (or coughing or straining) can one have assurance that there is no obstruction in the needle or manometer, and that the needle is free in the subarachnoid space. Similarly, an apparently normal response to jugular compression can occur in spite of complete spinal subarachnoid block if the patient holds his breath or strains during jugular compression.

Sugar—Normally the level of the sugar in the fluid is a reflection of the level in the blood. In fasting individuals the cerebrospinal fluid sugar content varies between 50 and 80 mg. per 100 cc., which is approximately two-thirds of the serum sugar content. Since punctures are not ordinarily performed under fasting conditions, values between 50 and 100 mg. per 100 cc. are considered normal. If the blood sugar is increased by the administration of glucose, the spinal fluid sugar will also be increased. There will be a lag of several hours between the two, and the spinal fluid will never reach the heights obtained by the blood. Conversely, if the blood sugar is lowered by the administration of insulin, the spinal fluid sugar will fall.

An increased sugar content in the cerebrospinal fluid is found in patients with manifestation of hyperglycemia, such as commonly seen in diabetes mellitus and uremia. Most systemic diseases are accompanied by some rise in the blood sugar, so it is not uncommon to find slightly increased values in the cerebrospinal fluid. A low cerebrospinal fluid sugar is with few exceptions indicative of an infection of the meninges. The exceptions are insulin shock and other rare cases of hyperinsulinism due to pancreatic tumors. For practical purposes a spinal fluid sugar content below 40 mg. means infection of the meninges. With most acute pyogenic infections, the sugar content rapidly falls to levels below 20 mg. per 100 cc. In the subacute meningitides, such as tuberculous meningitis, values are more commonly in the range of 20 to 40 mg. The sugar content may be occasionally low in syphilitic meningitis and dementia paralytica. Virus infections do not, as a rule, cause any change in the sugar content of the fluid. Meningeal reactions to septic foci in the cranium outside of the meninges such as sinus thrombosis and epidural abscesses which may be accompanied by a marked

pleocytosis are not accompanied by a decrease in the cerebrospinal fluid sugar content. Similarly, normal values are found in patients with a meningeal reaction to foreign substances injected into the cerebrospinal fluid (air, lipiodol, sera, etc.). With progress of the disease in acute purulent meningitis, the cerebrospinal fluid sugar decreases in amount or remains extremely low. With recovery it returns to normal. In patients treated with the sulfonamides, there is often a rise in the cerebrospinal fluid sugar content before the cellular reaction disappears. This is due to the bacteriostatic action of the drug in the fluid.

Chlorides—The chloride level in the cerebrospinal fluid is directly related to the level of this substance in the blood, and any change in the blood level is reflected by a similar change in the cerebrospinal fluid. There is only one exception. A very great increase in the protein content of the cerebrospinal fluid causes a decrease in the chloride content of the fluid, as would be expected from the Donnan theory.

In clinical practice the only condition with an increase in the chloride content of the blood and the cerebrospinal fluid is uremia. A reduction of the chloride content is common in most acute and chronic infections, with vomiting and in Addison's disease. It was at one time thought that a low cerebrospinal fluid chloride content was diagnostic of tuberculous meningitis. This, of course, is not true. It is common to have low blood and cerebrospinal fluid chlorides in tuberculous meningitis, but values equally low have been found in the acute bacterial meningitides, and in patients with pernicious vomiting or Addison's disease. As a rule, however, the average chloride content is lower in tuberculous meningitis, where readings of 525 to 625 mg. per 100 cc. are not uncommon, than in the acute purulent meningitides, which usually have values in the range of 575 to 675 mg.

Bacteriologic Studies

These are the same as for any other body fluid and require no special comment.

Special Diagnostic Tests

Pneumo-encephalography—This consists of the replacement of cerebrospinal fluid by a gas through a needle inserted into the subarachnoid space between the lumbar vertebrae or into the cisterna magna while the patient is maintained in the sitting position. Two needles may be used in lumbar encephalography.

Single-Needle Method—This method consists of an alternate withdrawal of cerebrospinal fluid and replacement with room air by means of a syringe attached directly to the needle.

Double-Needle Method—Two lumbar punctures may be performed with but slightly more difficulty to operator or trauma to the patient. With two needles in place, one above the other, an attempt may be made to maintain a constant pressure during replacement by introducing gas at the upper needle with a syringe while fluid is allowed to escape from the lower. Several types of apparatus have been described by means of which the cerebrospinal fluid may be automatically replaced by gas. The principle of any simultaneous replacement apparatus is quite simple. Spinal fluid drains from the lower lumbar-puncture needle by tubing through one of two openings into an otherwise closed bottle. This fluid displaces an equivalent volume of gas from the bottle through the other opening and from it to the upper needle in the subarachnoid.

Roentgen Exposures—Roentgenograms may be taken with the patient in the erect or recumbent position. Routine stereoscopic face-forward (anteroposterior), right and left lateral exposures should be made as soon after the termination of replacement as possible. The sooner the roentgenograms are taken the better, especially when oxygen is used. In cases of suspected temporal lobe lesions, lateral stereoscopic views are taken with the patient recumbent and the suspected lobe uppermost. The operator should be present to direct the taking of special views. In suspected occipital lesions, exposures are made with the patient lying face-down on the cassette. Exact centering of the patient's head for all pictures is essential. The entire procedure may be wasted by failure to obtain true lateral and exact anteroposterior x-ray films.

Bubble Method—Much of the information given by a complete air encephalogram may be gained by the so-called "bubble" method, but this usually shows only the ventricles, and may fail to do that. A cistern puncture is performed in the sitting posture and 20 to 30 cc. of fluid is withdrawn and replaced by an equivalent amount of air. The roentgenograms are then taken, in the recumbent position. The bubble of air outlines only the uppermost portion of the ventricles so that a number of views is necessary to outline the whole system. Familiarity with the pictures of complete filling is necessary for interpretation. The resulting disturbance of the patient is however much less than that from complete fillings, and the method is preferred in many clinics.

Air encephalography, besides causing the patient considerable headache, is not without dangers, and should not be embarked upon without diagnostic objective. Its value in treatment of traumatic headache is now doubtful.

Pneumomyelography — This is the radiographic demonstration of the spinal subarachnoid space and structures outlined by it following replacement of cerebrospinal fluid by air.

Indications—It is of value (1) in demonstrating the lower level of complete subarachnoid block, and (2) in outlining the lumbar and caudal subarachnoid space.

Technic—Gas should be evacuated from intestines as for scout films of the abdomen. Lumbar puncture is performed with the patient on an x-ray tilt table. From 40 to 50 cc. of fluid is removed, and the table is tilted so that the pelvis is 15 degrees higher than the head. Any fluid left in the lumbar sac is allowed to drain, and a quantity of gas (air or oxygen) equal to the total amount of fluid removed is injected. (Use a 50 cc. syringe with rubber-tube connection and introduce air slowly.) After the needle is removed, the table is tilted until the pelvis is 25 degrees higher than the head, and roentgen exposures are taken as indicated. Fluoroscopy is not useful in this procedure. The patient's pelvis should be kept elevated above his head for twenty-four hours.

Radio-Opaque Oil Myelography—Lipiodol (or other opaque oils) myelography is the radiographic demonstration of the spinal subarachnoid space and structures outlined by replacement of small volumes of cerebrospinal fluid by halogenated oils.

Indications—Lipiodol myelography is valuable (1) in locating the site of lesions of the spinal cord where complete or incomplete subarachnoid block has been demonstrated by lumbar or combined lumbar and cisternal punctures but in which exact localization and extent of the lesion causing the block cannot be determined by careful neurologic examination, and (2) in outlining lesions of the cauda equina. The use of lipiodol should be restricted to those instances where localization by neurologic means is impossible, or where the results of air injection are unsatisfactory. After completion of the test the oil should be removed.

Cerebrospinal Fluid Syndromes

Diseases Primarily of the Nervous System

I. Trauma

A. *Craniocerebral trauma* may result in blood in the cerebrospinal fluid due to contusion or laceration of the brain, or one or more meningeal vessels. The pressure may also be elevated either because of cerebral edema or accumulation of blood.

B. *Extradural hematoma* is associated with a high cerebrospinal fluid pressure. If there has been coincident damage to the brain or leptomeninges, the fluid is bloody; if not, it is clear and colorless.

C. *Subdural hematòma* is the most difficult complication of trauma to diagnose or exclude. If the cerebrospinal fluid is examined within a week of the time of injury, it will be found to be bloody and under an increased pressure, unless the patient is dehydrated or has had several previous punctures. Later the cerebrospinal fluid is xanthochromic and after several weeks it is clear and colorless. At this stage the pressure may or may not be elevated, but diagnosis is extremely difficult unless it is so. If the fluid is clear, the protein and cellular content will be normal. Bloody or xanthrochromic fluids may have an increased cell

count and protein content as the result of the blood itself and the reaction of the meninges to the blood.

An increased cerebrospinal fluid pressure is in favor of the diagnosis of subdural hematoma in a patient with a clinical picture compatible with this diagnosis. On the other hand, the finding of a low or normal pressure does not exclude the diagnosis.

D. *Spinal fracture* or dislocation may distort the spinal canal sufficiently to cause partial or complete dynamic block and an increased protein in the fluid below the level of the block. In such cases prompt laminectomy must be seriously considered.

E. *Herniation of an intervertebral disc* is associated with elevation of cerebrospinal fluid protein in about 50 per cent of cases and rarely with partial or complete dynamic block.[2,3] Protein values higher than 100 mg. per cent are against the diagnosis of ruptured disc.

II. Infections

A. *Epidural Infections*

1. *Osteomyelitis* of the skull secondary to fracture or sinus disease usually produces no change in the cerebrospinal fluid unless an extradural abscess is formed or a dural sinus infected. The latter is quite common in patients with mastoiditis untreated or uncontrolled by sulfonamides or penicillin and is accompanied by changes in the cerebrospinal fluid which are described by the terms "sympathetic meningitis" or "aseptic meningeal reactions." These changes are increased pressure, pleocytosis ranging from 5–5,000 white blood cells per cu. mm. with a predominance of polymorphonuclear leukocytes, slight or moderate increase in protein content (rarely above 100 mg. per cent), *normal sugar content*, sterility on bacteriologic culture, and of course, a negative Wassermann reaction. The gold sol curve will show various abnormalities in about 20 per cent of the patients. This combination of abnormalities is often distinguishable from acute purulent meningitis only by the normal sugar content and absence of bacteria and from acute syphilitic meningitis by the negative Wassermann reaction. As will be noted below an aseptic meningeal reaction may be caused by the presence of a purulent exudate in the extradural or subdural spaces or in the parenchyma of the brain (brain abscess). Rarely an acute necrosis of cerebral tissue adjacent to the ventricular system as a result of cerebral vascular accident or tumor may produce the reaction.

2. *Osteomyelitis of the spine*, whether tuberculous or pyogenic, will not produce cerebrospinal fluid abnormalities until collapse of the vertebrae has caused enough deformity of the spinal canal to produce complete or partial block with signs of cord compression or unless an epidural abscess has formed. The cerebrospinal fluid changes in the former are then indistinguishable from those due to spinal cord tumor (dynamic block, elevated protein, slight to moderate pleocytosis, and progressive xanthochromia) and the diagnostic differentiation is on the basis of x-ray changes, etc. The cerebrospinal fluid findings in the latter are considered below.

3. *Spinal epidural abscess* is a true neurologic emergency and its early diagnosis and prompt surgical treatment are as imperative as those of perforated peptic ulcer. If lumbar puncture is performed at the level of the abscess the diagnosis should be made without piercing the dura (see above under "Technic of Obtaining Fluid"). If puncture is performed below the level of the abscess (as one should try to do) the cerebrospinal fluid abnormalities are as follows: partial or complete dynamic block in nearly every case, pleocytosis in the majority of cases which may range from 5–2,000 white blood cells per cu. mm. with predominance of polymorphonuclears, high protein (almost always above 100 mg. per cent), and normal sugar. Operation should be performed immediately after the diagnosis is established, as every hour of delay increases the likelihood of permanent and irreparable damage to the spinal cord.

B. *Subdural Infections*

Subdural empyema is usually secondary to frontal sinus infection. It produces in the cerebrospinal fluid the changes characteristic of the so-called aseptic meningeal reaction: normal or increased pressure (up to 350 mm. water), pleocytosis (15–800 w.b.c. per cu. mm. with 5 per cent or more poly-

morphonuclears), moderate elevation of protein (up to 190 mg. per cent), and normal sugar.[4] Treatment is adequate drainage of the infected subdural space plus indicated bacteriostatic therapy.

C. *Infections of Dural Sinuses*

Thrombosis of a cerebral venous sinus (lateral sinus thrombosis, etc.) as result of infection is accompanied by changes in the cerebrospinal fluid as described under the term "aseptic meningeal reaction" (see above).

D. *Infections of Leptomeninges and/or Ependyma*

1. Acute purulent meningitis due to any of the pyogenic bacteria produces the following cerebrospinal fluid abnormalities: high initial pressure (200 mm. or over), marked pleocytosis (200 to 20,000 white blood cells per cu. mm. with a high percentage of polymorphonuclears), elevation of total protein in proportion to the pleocytosis, progressively decreased sugar content (45–0 mg. per cent), moderately diminished chloride content (700–550 mg. per cent), and various abnormalities in the gold curve usually of the mid-zone or end-zone type. Smear or culture permits identification of the infecting organism.

2. *Tuberculous meningitis* is characteristically subacute rather than acute and the cerebrospinal fluid abnormalities are correspondingly less severe than those just described. Initial pressure is elevated (200 mm. or more), there is moderate pleocytosis (20–500 white blood cells per cu. mm., 5–50 per cent polymorphonuclear), protein content is increased (50–500 mg. per cent), sugar content is nearly always low (45–25 mg.) and falls progressively, though it is rarely normal early in the course of the disease, chlorides are low and also fall progressively, occasionally to below 500 mg. per cent, and the gold curve is abnormal in about 70 per cent of the cases. Tubercle bacilli may be identified by careful examination of a stained smear of the centrifuged specimen or of the clot that generally forms in the fluid on standing over night. Guinea pig inoculation will also establish the diagnosis, though not usually before the patient has died.

3. *Syphilitic meningitis* is also a subacute meningitis with slight to marked pleocytosis and increase in protein, but the sugar and chloride content are normal or only moderately decreased (rarely below 35 mg. per cent for sugar or 650 mg. per cent for chloride), the gold curve is abnormal (first or mid-zone) in 95 per cent of cases and the Wassermann reaction is regularly positive.

4. *Choriomeningitis ("benign" lymphocytic meningitis)* is characterized by the following cerebrospinal fluid abnormalities: slight to moderate increase in pressure in the majority of cases (200–350 mm.), slight to marked pleocytosis (20–2,000 white blood cells per cu. mm.) with 70–100 per cent lymphocytes, slight or no increase in protein content (rarely over 70 mg. per cent), slight or no decrease in sugar content (rarely below 50 mg. per cent) or chloride content (rarely below 650 mg. per cent), and occasional abnormality of any type in the gold sol curve. With suitable technics the virus may be cultured from the cerebrospinal fluid or its presence inferred by serologic test.

5. *Mumps meningitis,* as evidenced by inflammatory changes in the cerebrospinal fluid, occurs in a very high percentage of patients with any form of mumps, including those with no clinical evidence of meningeal involvement. Both in the last war and in the present war, observers have noticed in the course of mumps epidemics in army camps cases which showed meningitis presumably due to a filterable virus, with no other signs of mumps (i.e. no adenitis, orchitis, or pancreatitis). Such cases are presumed to be ones of pure mumps meningitis, though in the absence of adequate serologic or cultural tests for the disease, this presumption cannot be definitely proved. The cerebrospinal fluid abnormalities in patients with mumps meningitis are identical with those just described for choriomeningitis except, of course, for the results of serologic and cultural tests.

6. *Torula (yeast) meningitis* is a rare disease which produces essentially the same cerebrospinal fluid abnormalities as tuberculous meningitis. It is differentiated by the absence of tubercle bacilli and the finding of yeast organisms in stained smears or culture.

E. *Infections of the parenchyma (encephalitides)*

1. *Bacterial infections of the parenchyma* may give rise to rapidly spreading necrosis of cerebral tissue and death ("acute cerebral abscess" or "cerebral gangrene"). If the infection is localized and walled off, true abscess formation results. The cerebrospinal fluid abnormalities associated with cerebral abscess are essentially those characteristic of any "aseptic meningeal reaction" (cf. epidural infections). Since an abscess and the edema surrounding it constitute a space-occupying lesion, the pressure is apt to be particularly high. If the abscess ruptures into a ventricle or into the subarachnoid space, the patient's condition changes dramatically for the worse and simultaneously the cerebrospinal fluid becomes grossly purulent and the sugar content rapidly falls to a low level.

F. *Infections of the meninges and parenchyma (meningoencephalitides and/or meningomyelitides)*

1. *Syphilitic meningoencephalitis (dementia paralytica, general paresis)*—The cerebrospinal fluid abnormalities which are to be listed as characteristic of this form of neurosyphilis are those found in "untreated" cases. With effective therapy any or all of the cerebrospinal fluid abnormalities may disappear. These abnormalities are as follows: slight to moderate pleocytosis (15–200 w. b. c. per cu. mm.) chiefly lymphocytes, moderate increase in protein content (50–150 mg. per cent), first-zone gold curve in 85 per cent of patients and a mid-zone curve in the remaining 15 per cent, and a strongly positive Wassermann reaction in a small amount of the fluid (0.05 to 0.1 cc.).

Tabes dorsalis may also be conveniently considered here though the exact nature of the pathologic process (i.e. the site of the syphilitic process responsible for the eventual destruction of the posterior columns of the spinal cord) is as yet obscure. The characteristic cerebrospinal fluid abnormalities in early active cases are not essentially different from those accompanying syphilitic meningoencephalitis, but since many patients are not examined until late in the disease when the acute inflammatory process has subsided, the abnormalities in the fluid in the average are less severe. These abnormalities are slight or moderate pleocytosis in 65 per cent (5–200 w. b. c. per cu. mm.) chiefly lymphocytes, slight or moderate increase in protein content in 50 per cent (50–150 mg. per cent), first-zone gold curve in 10 per cent, mid-zone in 35 per cent, and normal or doubtful in 55 per cent, and a positive Wassermann reaction in 80 per cent, but only in a large amount of fluid (0.2–0.6 cc.) in many of these. It is important to remember that tabes may be a self-limited disease, in which case after spontaneous cure has occurred the cerebrospinal fluid is entirely normal, and that it frequently responds partially or wholly to routine antisyphilitic treatment with trivalent arsenic, bismuth, and mercury. To be sure there are also cases of tabes that are refractory to any but fever therapy, tryparsamide, or possibly penicillin.

Asymptomatic neurosyphilis is a clinical rather than a pathologic diagnosis and is used to group together all patients with any cerebrospinal fluid abnormality attributable to syphilis of the central nervous system who nevertheless have no clinical evidence (signs or symptoms) of such involvement. The cerebrospinal fluid abnormality may vary from nothing but a weakly positive Wassermann reaction to the complete picture of pleocytosis, increased protein content, first-zone gold curve, and strongly positive Wassermann reaction in a small amount of fluid.

For the cerebrospinal fluid abnormalities found in patient with *syphilitic meningitis* see page 314.

The logical consequence of the above paragraphs is this: it is not possible to decide what type of neurosyphilis a patient has from the examination of the cerebrospinal fluid alone. The most one can say, as far as a single examination goes, is that a weakly positive fluid makes the diagnosis of syphilitic meningoencephalitis very unlikely. Much more can be inferred from the changes (or lack of them) in the cerebrospinal fluid over a period of time and in response to various forms of treatment, but in most cases a satisfactory diagnosis can only be made by considering together all the available clinical, historical, and laboratory data.

2. *Septic emboli* to the brain may complicate any pulmonary or cardiac infection. Those coming from a pulmonary abscess or bronchiectasis will frequently give rise to a large cerebral abscess or an acute meningitis. Those coming from subacute bacterial endocarditis will usually set up many small abscesses in the substance and on the surface of the brain which never grow very large but give rise to a rather characteristic spinal fluid picture. It is particularly important to recognize the picture because approximately 20 per cent of the cases[5] of subacute bacterial endocarditis have neurologic symptoms or signs as their presenting complaint. The cerebrospinal fluid findings are as follows: pleocytosis (100–1,000 cells per cu. mm.) chiefly polymorphonuclear cells, occasionally a few or many red blood cells (50–1,000 per cu. mm.), increased protein content (50–125 mg. per cent), various abnormalities in the gold sol curve, normal sugar content, and negative cultures.

3. *Poliomyelitis (acute anterior poliomyelitis)* is associated with the following cerebrospinal fluid abnormalities: pleocytosis which is higher in the pre-paralytic stage and falls rapidly after the onset of paralysis with an average count of about 160 w. b. c. per cu. mm. at the time of onset of paralysis and about 35 w. b. c. per cu. mm. two weeks later, and a normal or slightly increased protein content at the time of onset of paralysis rising to an average of 150 mg. per cent three weeks later.* A high percentage of polymorphonuclear cells (up to 50 per cent) is found early in the course of the disease and in patients with a high cell count. About 20 per cent of patients show a mid-zone gold curve. The sugar content is normal in this disease as in others caused by a filtrable virus.

4. *Herpes Zoster*—Cerebrospinal fluid abnormalities usually associated with this disease are mild pleocytosis (usually 5–50 w. b. c. per cu. mm. chiefly lymphocytes), and an increased protein content (50–100 mg. per cent) in about one half the patients. The spinal fluid changes may precede the cutaneous eruption.

5. *Rabies* is associated with the following cerebrospinal fluid abnormalities: pleocytosis (5–3,000 w. b. c. per cu. mm.), normal or slightly increased protein content (30–90 mg. per cent), and an occasional mid-zone or first-zone gold curve. Encephalomyelitis following administration of anti-rabitic vaccine is presumably the same etiologically as spontaneous or accidental rabies. The spinal fluid findings associated with encephalomyelitis following anti-rabitic vaccine are essentially the same as those associated with rabies.

6. *Encephalitis lethargica* (epidemic encephalitis, von Economo's encephalitis) is associated with the following cerebrospinal fluid findings: the pressure is normal, there is a slight pleocytosis which disappears after the first few weeks and rarely exceeds 100 w. b. c. per cu. mm., protein content is normal or slightly increased (rarely as high as 100 mg. per cent), sugar content is of course normal (the idea originally current that it was frequently increased is erroneous), chloride content is normal, and the colloidal gold test shows a mid-zone curve in an occasional patient. The diagnosis of epidemic encephalitis is rarely tenable at the present time.

7. *Eastern equine encephalomyelitis* is a disease of horses but small epidemics of the disease have occurred in humans. The cerebrospinal fluid abnormalities associated with the illness are a mild to marked pleocytosis (25 to 1,000 per cu. mm.), with a high percentage of polymorphonuclear leukocytes, and a moderate increase in the protein content.

8. *Western equine encephalomyelitis* is characterized by the same cerebrospinal fluid abnormalities as is the Eastern type.[6]

9. *The St. Louis and Japanese B* types of encephalitis were characterized by cerebrospinal fluid abnormalities similar to those found in encephalitis lethargica.[6, 7]

10. *Trypanosomiasis* is associated with pleocytosis of varying degrees (from 5–2,000 w. b. c. per cu. mm., mainly lymphocytes), an increase in protein content (rarely over 100 mg. per cent), and frequently the presence of organisms in the cerebrospinal fluid.

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* It should be noted that the typical albumine-cytologic dissociation may be found in the fluids of patients with anterior poliomyelitis several weeks after the onset of the disease.

11. *Toxoplasmosis*[8] is associated with a moderate to marked pleocytosis (50–1,000 w. b. c. per cu. mm., chiefly lymphocytes though not always so), the presence of red blood cells, occasionally in large number, normal or moderately increased total protein, and normal sugar and chloride content. Organisms may be found in the fluid.

III. Vascular disease

A. *Arterial occlusion* due to either thrombosis or aseptic embolus are indistinguishable on the basis of cerebrospinal fluid findings. These findings are as follows: normal pressure in 80 per cent of the cases (rarely increased over 250 mm.), uniformly clear color except for a very rare bloody fluid, normal w. b. c. count in 90 per cent of the cases, normal or slightly increased protein content, normal sugar and chloride content, and occasional abnormality of the gold sol curve usually of the mid-zone type.

B. *Intracerebral hemorrhage* produces the following cerebrospinal fluid abnormalities: pressure above 200 mm. of water in 60 per cent of the cases and above 400 mm. in 20 per cent, fluid bloody in about 70 per cent of cases and clear in about 30 per cent, slight or moderate pleocytosis in the 30 per cent with clear fluid, normal or slightly increased protein content in the same 30 per cent, normal sugar and chloride content in nearly every case and various abnormalities in the colloidal gold curve, usually due to the presence of blood serum in the fluid.

C. *Subarachnoid hemorrhage* is characterized by the presence of uniformly bloody spinal fluid with red blood cell count ranging up to 3.5 million per cu. mm., almost always under greatly increased pressure. The presence of blood in the cerebrospinal fluid does not indicate whether the bleeding is the result of rupture of an aneurysm in the subarachnoid space or is secondary to escape of blood into the subarachnoid space or ventricular system from an intracerebral hemorrhage or cerebral trauma.

D. *Cerebral arteriosclerosis* is not usually associated with cerebrospinal fluid abnormalities unless there is some complication such as cerebral thrombosis or hemorrhage, congestive heart failure or uremia. A slight pleocytosis (5–25 w. b. c. per cu. mm.) is present in about 15 per cent of the patients and a slight increase in the protein content (45–80 mg. per cent) in about the same proportion of patients. If a patient has an initial pressure greater than 200 mm. of water, despite the fact that he is well relaxed and has a normal systemic venous pressure, one should be extremely cautious about attributing his neurologic signs or symptoms to "cerebral arteriosclerosis."

IV. Tumors of the central nervous system

A. *Brain tumor* typically is associated with increased pressure and an increased protein content. About 30 per cent of patients will show a normal pressure or a normal protein content or both and a similar percentage will show a slight or moderate pleocytosis (5–100 w. b. c. per cu. mm.). Very rarely a marked pleocytosis may be found particularly if the tumor is close to one of the lateral ventricles or the third ventricle. Of all brain tumors, acoustic neuromas are most apt to show a high protein content (above 100 mg. per cent in 85 per cent). It is not possible to differentiate between primary and secondary (that is, metastatic) brain tumor on the basis of the spinal fluid examination.

B. *Spinal cord tumors* typically produce a partial or complete dynamic block below the level of the tumor. In the absence of such a block, diagnosis is rarely justifiable although such cases have been reported. If the block is complete, the fluid below it will be yellow in color and contain a large amount of protein. If the block is partial, the fluid will be clear and the protein content only moderately elevated. It is not possible to differentiate on the basis of the cerebrospinal fluid abnormalities between intradural, extradural, and intramedullary spinal cord tumors.

V. Deficiency diseases

A. *Combined system disease* is generally associated with pernicious anemia and usually produces no change in the cerebrospinal fluid. An occasional slight pleocytosis (5–10 w. b. c. per cu. mm.) is seen as well as an increase in protein content (45–95 mg. per cent) in about 20 per cent of patients.

B. *Polyneuritis* in patients with chronic alcoholism is presumably due to deficiency in vitamin B complex and is supposed to be indistinguishable from the polyneuritis found in beri-beri. In such cases the cerebrospinal fluid is ordinarily normal. About 10 per cent of cases will show a slight pleocytosis (up to 25 w. b. c. per cu. mm.) and about 15 per cent a slight or moderate increase in protein up to 100 mg. per cent.

C. *Pellagra* may be associated with polyneuritis. In such cases the cerebrospinal fluid syndrome is similar to that found in alcoholic or vitamin B deficiency neuritis.

VI. Intoxications of the central nervous system

A. *Lead poisoning* may cause either polyneuritis or encephalopathy. In patients with polyneuritis the cerebrospinal fluid is usually normal although a small percentage of patients show a slight increase in protein and occasionally an abnormal gold sol curve. Patients (usually infants) with lead encephalopathy usually have marked abnormalities in the cerebrospinal fluid: the pressure is elevated, sometimes up to 1,000 mm. of water, the fluid is occasionally yellow, the w. b. c. count varies from normal to several thousand cells per cu. mm. though the pleocytosis is usually mild or moderate, the protein content is usually increased, often above 100 mg. per cent, and the colloidal gold reaction may show any type of curve. Chemical examination of the cerebrospinal fluid will show the presence of lead.

B. *Arsenic,* like lead, may produce a polyneuritis but the organic arsenicals which are routinely used in the treatment of syphilis may also produce a hemorrhagic encephalitis. Patients with arsenical neuritis generally have a normal spinal fluid except for an increase in the protein content. Patients with hemorrhagic encephalitis generally have normal or moderately increased pressure (up to 250 mm. of water) and occasionally a slight pleocytosis or slight to moderate increase in protein content. Cerebrospinal fluid from such patients does not usually contain red blood cells.

C. *Mercury* may also produce a polyneuritis. The cerebrospinal fluid findings are essentially the same as those described in the cases due to lead or arsenic.

D. *Carbon monoxide* poisoning ordinarily produces no changes in the cerebrospinal fluid. Occasionally one finds a moderate increase in pressure and slight pleocytosis or increased protein content may also be present.

E. *Bromides and other sedative drugs* usually produce no change in the cerebrospinal fluid except for the presence of the drug in the fluid, the detection of which requires a special test and ordinarily constitutes the evidence by which the diagnosis is established. Acute poisoning with bromides and other drugs such as morphine or barbiturates is also ordinarily associated with normal cerebrospinal fluid findings although the pressure may be high if the respiratory rate is low and slight pleocytosis or increased protein content may occur.

VII. Diseases of the nervous system of unknown etiology

A. *Multiple sclerosis* is associated with the following cerebrospinal fluid abnormalities: slight pleocytosis (5–50 w. b. c. per cu. mm.) in 30 per cent of patients, slight to moderate increase in protein content (rarely over 100 mg. per cent) in a similar percentage of patients, and a first- or mid-zone gold curve in about 50 per cent of patients. An entirely normal spinal fluid is present in only about 30 per cent of patients with multiple sclerosis.

B. *Acute encephalomyelitis, neuromyelitis optica, etc.* which in many patients probably represents an acute attack of multiple sclerosis is associated with the following cerebrospinal fluid abnormalities: mild or moderate pleocytosis (10–200 w. b. c. per cu. mm.), slight to moderate increase in protein content in 60 per cent and a mid-zone or first-zone gold sol curve in a similar percentage.

C. *Schilder's disease* produces cerebrospinal fluid abnormalities which are essentially the same as those described for multiple sclerosis.

D. *Syringomyelia* is associated with the following cerebrospinal fluid abnormalities: slight to moderate increase in protein con-

tent (rarely above 100 mg. per cent) in 50 per cent of patients, and slight pleocytosis (5–20 w. b. c. per cu. mm.) in 15 per cent of patients. Occasionally the syrinx becomes wide enough to produce a spinal block in which case the dynamic tests reveal the usual absence of response to jugular compression and the protein in the spinal fluid below the block is markedly increased. Such cases can be differentiated from spinal cord tumor only by operation.

E. *Friedreich's ataxia* usually produces no cerebrospinal fluid abnormalities. Occasionally a slight lymphocytosis or increase in protein is found.

F. *Amyotrophic lateral sclerosis* and progressive muscular atrophy ordinarily produce no cerebrospinal fluid abnormality except that the protein content is increased in about one third of the patients (rarely above 75 mg. per cent).

G. *Neuritic muscular atrophy* (Charcot-Marie-Tooth form of muscular atrophy) usually produces no abnormality of the cerebrospinal fluid. Occasionally there may be a slight increase in the protein content.

H. *"Epilepsy"* (convulsive seizures, cause unknown) is usually associated with entirely normal cerebrospinal fluid. Five to 10 per cent of the patients may show a slight increase in pressure (180–250 mm.), an increased protein content (45–75 mg.), or slight pleocytosis. The diagnosis of idiopathic epilepsy should be made with caution in any patient with an abnormality in the cerebrospinal fluid.

I. *"Infectious" Polyneuritis*—Polyneuritis may occasionally follow a mild generalized infection and for that reason as well as because of the nature of its onset it is often called infectious polyneuritis although no etiologic agent has ever been isolated. Such patients often present a clinical picture somewhat different from other forms of polyneuritis in that the facial nerves are also involved (facial diplegia). These cases have been described under the term "Guillain–Barré Syndrome." The cerebrospinal fluid pressure is usually normal and the fluid cell free (occasionally 5–25 cells may be found) but the protein content is usually moderately or greatly increased (up to 750 mg. per cent) and there is a mid-zone or occasionally an end-zone gold sol curve. Because of the high protein content the cerebrospinal fluid from these patients is frequently yellow in color. Albumino-cytologic dissociation, though usually present, is not diagnostic since it may be present in anterior poliomyelitis during the convalescent stage as well as in other conditions.

J. *Meningism* is defined clinically as the presence of signs and symptoms of meningeal irritation (headache, stiff neck, and Kernig's sign) at the onset of any acute febrile disease. No case should be diagnosed "meningism" in which there is actual infection of the meninges themselves or any infection close to the meninges. If these diagnostic criteria are followed, such cases will exhibit a uniform cerebrospinal fluid syndrome: increase in pressure, normal cell count, sugar content and colloidal gold reaction, and decreased protein and chloride content.

VIII. Diseases of the nervous system with normal cerebrospinal fluid

The following diseases of the central nervous system are unassociated with any abnormality in the cerebrospinal fluid: amyotonia congenita, Bell's palsy, botulism, cerebral diplegia, dystonia musculorum deformans, Huntington's chorea, Leber's disease (familial optic neuritis), mental deficiency, migraine, myasthenia gravis, myotonia dystrophica, narcolepsy, otitic vertigo (Ménière's disease), periodic familial paralysis, progressive muscular dystrophy, retinitis pigmentosa, tetanus, and trigeminal neuralgia.

Diseases not primarily of the nervous system but in which the nervous system may be affected.

A. *Bacterial infections*

1. *Spirochetal jaundice* (Weil's disease) produces the following abnormalities in the cerebrospinal fluid: a clear or yellow colored fluid depending on the severity of the jaundice, pleocytosis of slight or moderate degree, and a slight increase in protein content.

2. *Undulant fever* is associated with the following abnormalities in the cerebrospinal fluid: increased pressure, moderate degree

of pleocytosis (25–400 w. b. c. per cu. mm.), and moderate to marked increase in protein content. The organisms can frequently be cultured from the spinal fluid.

3. *Tick borne relapsing fever* (treponema recurrentis) has been reported to produce signs of meningeal inflammation in about 25 per cent of cases.[9] In these cases the cerebrospinal fluid abnormalities reported were increased pressure and slight or marked pleocytosis (as high as 2,000 w. b. c. per cu. mm.).

4. *Post-diphtheritic polyneuritis* may be associated with a slight to moderate increase in protein content (up to 325 mg. per cent) and occasionally a mid-zone colloidal gold curve.

B. *Rickettsial infection*

Rickettsial infections in humans (European typhus, Mexican typhus, Rocky Mountain spotted fever, and tsutsugamushi fever) may be accompanied by a meningeal reaction with the following abnormalities in the cerebrospinal fluid: slight to moderate pleocytosis (5–250 w. b. c. per cu. mm.), slight to moderate increase in protein content (45 to 200 mg. per cent), and an increased pressure.

C. *Virus infections*

1. Any of the *acute exanthemata* (variola, varicella, vaccinia, rubeola, rubella) may rarely or occasionally be followed by an encephalomyelitis. In such cases the cerebrospinal fluid shows a normal or increased pressure, slight to moderate pleocytosis (5–300 w. b. c. per cu. mm.), a normal or increased protein content (up to 250 mg. per cent), a normal or mid-zone gold sol curve, and, of course, normal sugar and chloride content.

2. *Virus pneumonia* may rarely be complicated or followed by encephalomyelitis. In one such case observed by the authors the pressure was normal on each of six lumbar punctures. The cell count varied from 7 to 115 w. b. c. per cu. mm., and the total protein varied from 66 to 330 mg. per cent. These six punctures were all done in the first month of the disease. Two and one-half months after the onset the only abnormality in the cerebrospinal fluid was a total protein of 167 mg. per cent.

3. *Dengue fever* is often associated with signs of meningeal irritation. These signs and symptoms are said to be relieved by lumbar puncture and the cerebrospinal fluid findings reported in such cases are consistent with meningism.[10]

D. *Parasitic infections*

1. *Malaria* may directly affect the central nervous system (cerebral malaria). Such cases are usually due to P. falciparum (aestivo-autumnal malaria). In one report on 12 cases[11] the cerebrospinal fluid was regularly under increased pressure and pleocytosis was present in those cases manifesting marked meningeal symptoms. In a more recent report on 53 patients[12] the pressure was normal in the majority of patients and the cerebrospinal fluid was otherwise entirely normal except for one case with frankly bloody fluid attributed to a subarachnoid hemorrhage.

The biologically false tests for syphilis which are not infrequently found in the serum of patients with malaria are not accompanied by a positive test in the cerebrospinal fluid.[13]

2. *Trichinosis* usually produces no change in the cerebrospinal fluid. Occasionally there is a slight pleocytosis and increased protein content, and motile organisms may be found free in the cerebrospinal fluid.

3. *Cysticercus* infection may produce the following cerebrospinal fluid abnormalities: the pressure is usually high, fluid is occasionally xanthochromic, there is moderate pleocytosis (up to 300 w. b. c. per cu. mm.), protein content is moderately or markedly increased, and an abnormal colloidal gold curve of any type may be present. Fragments of the parasites or the cyst wall may be seen occasionally.

II. Metabolic diseases

A. *Diseases of endocrine glands*

1. *Diabetes mellitus* will cause alterations in the cerebrospinal fluid sugar content proportionate to the blood sugar content. If the latter is high, the former will be so also. If the latter is low (insulin shock), the former will be too. When there is an accompanying polyneuritis the protein content may be elevated (50 to 200 mg.).

2. *Hyperthyroidism* produces no abnormality except a diminution of protein content in the cerebrospinal fluid.

3. *Myxedema* produces the following abnormalities in the cerebrospinal fluid: a pressure of 200 mm. or above is not uncommon, a slight pleocytosis may be seen (up to 10 w. b. c. per cu. mm.), the protein content is nearly always increased (up to 240 mg. per cent), and a mid-zone colloidal gold curve is found in about 25 per cent of cases.

B. *Other metabolic diseases*

1. *Acute nephritis* may be associated with the following abnormalities in the cerebrospinal fluid: the pressure may be as high as 500–600 mm. particularly in the presence of edema, the protein content is not abnormal, but a first- or mid-zone gold sol curve is found in 50 or 60 per cent of the patients.

2. *Nephrosis* is associated with increased pressure, slight pleocytosis (6–8 w. b. c. per cu. mm.), and a mid-zone colloidal gold curve in about 50 per cent of patients.

3. *Uremia* is associated with the following cerebrospinal fluid abnormalities: increased pressure in 80 per cent, slight pleocytosis in 20 per cent, a slight increase in protein content (45–150 mg. per cent) in 40 per cent, increased chloride content (750–900 mg. per cent) in 50 per cent, and mid-zone colloidal gold curve in 10 per cent. In addition there is an increase in the nonprotein nitrogen content in the fluid in proportion to the nonprotein nitrogen in the blood serum.

4. *Jaundice* of moderate or severe degree is generally associated with a yellow color in the cerebrospinal fluid. The nature of the pigment responsible for this color is not known.

5. *Paget's disease* is not associated with abnormalities in the cerebrospinal fluid unless there are signs of involvement of the cortex, cranial nerves, or spinal cord. In such cases there may be an increase in the protein content of the cerebrospinal fluid and rarely an increase in the pressure. If the vertebral involvement is sufficiently severe to cause spinal subarachnoid block, the usual changes in the fluid below the level of the block will be present.

III. Diseases of the circulatory system

Any condition which causes a rise in systemic venous pressure will produce a corresponding rise in cerebrospinal fluid pressure. Such conditions include right-sided heart failure, pericarditis with effusion, constrictive pericarditis, and occlusion of either the superior or inferior *vena cava*. No other abnormalities are present in the cerebrospinal fluid in any of these conditions.

IV. Diseases of uncertain etiology

A. *Leukemia* may occasionally involve the central nervous system. In the patient in whom there are signs of central nervous system involvement cerebrospinal fluid abnormalities include increased pressure in 35 per cent, increased protein (up to 400 mg. per cent), and pleocytosis (up to 8,000 w.b.c. per cu. mm.) in 41 per cent. Cases have been reported of spinal subarachnoid block associated with leukemia.

B. *Infectious mononucleosis* occasionally shows signs and symptoms of involvement of the central nervous system. In such cases, the cerebrospinal fluid shows mild pleocytosis and a slight increase in the protein content.

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Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Improving Penicillin Activity

Reducing Number of Doses—The advantage of fewer intramuscular injections may be achieved by giving the penicillin in a beeswax-peanut oil mixture but the total amount of the agent thus required is considerably increased. Leifer et al. (1945) found that a single 3,000,000 unit injection in beeswax-peanut oil produced no better results in gonorrhea than 1,000,000 units divided into five doses in saline solution, and Kinsman et al. (1945) reported relapses in cases of pneumococcic pneumonia treated with 4,000,000 units in beeswax-peanut oil with no relapses in the control series given only 120,000 units in divided doses in saline. Since, in addition, moderate and long persistent soreness at the site of injection in practically all instances, and generalized urticaria in 3 of 40 patients, was reported by Kirby et al. (1945), it seems that the beeswax-peanut oil mixture is still in the experimental stage. Trumper and Hutter (1944) found it possible to space injections 8 hours apart through chilling the deltoid site of injection by constant application of an ice bag, but the method requires the use of a cumbersome supporting harness and would not seem to be feasible for employment in cases of pneumonia.

Checking Excretion—Very interesting studies have been performed in the attempt to check the loss of penicillin through the renal tubules by administering with it a substance which would compete for the use of the same channel of excretion. Rammelkamp and Bradley (1943) gave diodrast and penicillin simultaneously intravenously, and Beyer et al. (1945) injected para-aminohippuric acid and penicillin at the same time into the vein. Both procedures considerably raised the serum level of penicillin. However, it seems to me that the method of Bronfenbrenner and Favour (1945) is more likely to be of practical value since they give benzoic acid at 4 hour intervals by mouth and penicillin intramuscularly 20 to 30 minutes after each dose of the benzoic acid. With the daily fluid intake limited to 1,000–1,500 cc. and the salt intake to 3 Gm., the penicillin level in the serum is said to be raised 4 to 8 times. But even this method does not maintain a demonstrable blood level beyond 3 or 4 hours though it does produce a much higher titer in the beginning.

Potentiation of Action—Animal experimentation regarding the alleged synergism of the sulfonamides and penicillin has yielded varied and conflicting results, and in the clinical reports of Dobson and Cutting (1945) and Appelbaum (1945), on the elimination of penicillin-sensitive organisms there is no convincing evidence of this potentiating action, but indeed it is only where the organisms are relatively penicillin-resistant that one might expect a synergistic action to be of advantage anyway. Synergistic action which would bring gram-negative and other very resistant organisms into the therapeutic range of penicillin would be highly desirable. Schwartzman (1945) found under experimental conditions that the addition of the amino acids methionine and threonine to the culture medium greatly enhanced the activity of penicillin against *E. coli;* it would certainly be fine if something of a practical nature were to come of this.

Modification of Penicillin—During the manufacture of penicillin three fractions appear: penicillins S, G, and X. The *in vitro* studies of Orey et al. (1945) revealed that most common pathogens are more sensitive to penicillin X alone than to commercial penicillin, which consists almost entirely of penicillin G; but I think it highly unlikely that anything of practical value will come of this very soon. Much more immediately applicable would seem to be the observations of Tainter et al. (1945), who found the benzyl ester of penicillin sufficiently superior to ordinary sodium penicillin to merit clinical trial; indeed they showed the new agent to be quite surprisingly effective when given by mouth in a small series of cases of impetigo.—HARRY BECKMAN, M. D.

Notes on Clinical Pathology

Editors—WALTER H. JAESCHKE, M. D., University of Wisconsin, Madison, and
S. B. PESSIN, M. D., Marquette University, Milwaukee

Laboratory Examinations in Anemias

The laboratory classification of anemia is a *cytologic* one based upon information gained from procedures that determine the number of red blood cells, the size of the red blood cells, and their hemoglobin content. The interpretation of these values in conjunction with the number of platelets, reticulocytes, white blood cells, and serum icterus index gives invaluable information. The calculations must be made from determinations done at one time on the same sample of blood. We speak, therefore, of the red blood cells in reference to their size and hemoglobin content: respectively normocytic, microcytic, and macrocytic; normochromic, hypochromic, and hyperchromic. If a clinician diagnoses an iron deficiency anemia, the laboratory expression would be a microcytic hypochromic anemia. However, since frequently the cause of the anemia is not known, the cytologic classification may suggest the cause of the anemia. Of the typical and more frequently encountered anemias, we have the following cytologic and etiologic correlations: *normochromic normocytic* anemias such as are seen in acute hemorrhage, acute hemolytic anemia, early bone marrow disturbance, and early phases of aplastic anemia; *normochromic microcytic* anemias as seen in chronic nephritis; *hypochromic normocytic* anemias as encountered in chronic hemorrhage, chronic hemolysis, carcinoma, and early iron deficiency states; *hypochromic microcytic* anemias of which iron deficiency and familial icterus are typical examples; *hypochromic macrocytic* anemias usually indicate a gastro-intestinal malignancy, pancreatic disease, and in some instances erythroblastosis. *Hyperchromic* anemia is always macrocytic such as pernicious anemia. These are usually due to the lack of maturation factor, interference with its utilization or defective storage. These anemias may be found in pregnancy, chronic diarrhea, cancer of the stomach, cirrhosis of the liver, achlorhydria, intestinal parasites, and aleukemic leukemia.

The interpretation may further be simplified by noting platelets and reticulocytes. The *platelets* are increased in acute hemolytic anemia and in some cases of chronic myeloid leukemia. They are decreased in acute leukemia, pernicious anemia, and thrombocytopenia. The *reticulocytes* are increased in acute hemolysis, familial icterus, erythroblastosis, sickle cell anemia, and pernicious anemia in the early phases of liver therapy. They are decreased in aplastic anemia, acute leukemia, and pernicious anemia in relapse. An increase of serum bilirubin (icterus index) is indicative of blood destruction.

There are other very helpful laboratory aids in the diagnosis of anemia which are frequently not employed although many of them are extremely important in the diagnosis. A youngster with jaundice, colic, and gallstones may be found to have microcytosis, increased red blood cell fragility, and acholuria which would make a diagnosis of familial icterus. Anemia in the negro may be sickle cell type characterized by latent sickling and slow sedimentation of the red blood cells. Finally one should not give liver to a case of "pernicious anemia" without a gastric analysis or fail to do a urinalysis thereby overlooking an anemia of chronic nephritis. Such a situation is not permissible any more than it is to make a diagnosis of sepsis lenta without blood cultures.

Summary: The cytologic classification of anemia frequently will suggest the cause of the anemia and hence will aid the clinician in the diagnosis and logical treatment of the problem. The following suggestions are, therefore, made: (1) Hematologic data should be compiled *before* any treatment is administered. (2) "Complete Blood Count" which is the "routine" with many physicians should be supplemented with hematocrit, platelet, and reticulocyte counts and icterus index determinations in order to classify an anemia cytologically. (3) Sternal aspiration marrow studies in the atypical cases to denote marrow complement and its activity.—J. F. KUZMA, M. D., Milwaukee.

As It Looks to Your State Board of Health

(These timely discussions of health problems are prepared by staff members as a special service to Wisconsin's physicians.)

Distribution of Dried Blood Plasma by the American Red Cross

Surplus dried blood plasma which has been returned by the Army and Navy to the American Red Cross is being distributed to the various states for civilian use on the basis of population, number of practicing physicians, and the number of general, pediatric, and maternity hospital beds. Wisconsin's first shipment arrived February 18, 1946, and will be distributed by the State Board of Health to the counties on the same basis used by the American Red Cross to pro-rate it to the states. The first shipment of 7,800 units is one-fourth of the annual quota allotted to Wisconsin.

Each unit package consists of a bottle of the dried plasma which was prepared from 500 cc. of the fluid plasma, a bottle of the fluid for placing it in solution, and the needles and rubber tubing necessary to transfer the water to the plasma bottle and the plasma when in solution into the patient's vein. Directions for this procedure are on the outside tins, of which there are two, one containing the bottle of dried plasma, the other a bottle of water. Each bottle of the plasma is arranged in a basket made of tape by which it can be hung to the standard in an inverted position.

Each hospital will receive one unit of plasma for each four beds, and each physician is to receive one unit. The plan of distribution is to send the first shipment to hospitals and ask physicians to call for their units at the hospital. When the supply is used up the hospital may request additional units from the State Laboratory of Hygiene. Physicians are to obtain replacement units by writing to the laboratory but are requested to obtain their first unit from the local hospital.

It seems appropriate here to reiterate some things which appeared on this page in the November, 1945, issue of the *Journal*. The prospect of the development by the State Board of Health of a plasma bank was discussed. It was pointed out that plasma does not cure shock but may prevent it if administered early enough and in sufficient quantity. It was also remarked that blood plasma does not take the place of whole blood; its greatest usefulness is in emergency to prevent shock and thus tide patients over a critical period until whole blood can be obtained. Plans for the blood plasma bank are going ahead as fast as plans can go these days. It is hoped that by the time the American Red Cross surplus plasma has been exhausted our bank will be ready to supply this important substance.

According to a letter from the area director for the American Red Cross, the State Board of Health is required to:

"1. Assume the responsibility for making an inventory of the plasma received so that it may be issued in time to insure its use before it becomes outdated. This is necessary because the surplus plasma is made up of lots bearing different expiration dates.

"2. Make the plasma available to all physicians licensed to practice medicine and surgery and to all acceptable hospitals for administering to any patient without charge to physician, hospital, or patient either for the product or for the cost of shipment.

"3. Encourage by all available means proper use of the plasma and maintain a record of its distribution.

"4. Submit periodic reports to the area medical director on the status of the program."

The letter states that "the chapter will assist the state or local department of health to achieve the objectives of the program and may be called upon to serve as a distributing center."—W. D. STOVALL, M. D., *Director, State Laboratory of Hygiene.*

. . . . THE PRESIDENT'S PAGE . . . .

Hospitals Are a Business

FOR many decades charity and hospitals were closely related. Hospitals are a product of the Christian era and the earlier hospitals were essentially charitable in character. During the middle ages hospitals flourished as the church expanded and medical arts improved. Many bishops were physicians and each diocese was required to support a hospital. A period of decadence set in at the close of the Thirty Years War and continued until the nineteenth century when the work of Lister in aseptic and antiseptic surgery introduced the great revolution in medicine and surgery that has continued into our times. With expanded medical efficiency came a parallel expansion of hospitals and hospital facilities, and the charity motive, inherited from the past, was incorporated into the new order.

However, with the development of new thinking that has promoted extensive state aid in numerous directions, and with social security and pensions in operation, the zeal for charity has languished, so today hospitals are a business. Although they stand as a product of the physician's skill and accomplishment, he has neglected to assert such control over their pecuniary operations as he has over their professional procedures. While hospitals were essentially charitable, this remissness is understandable. We have, however, come to a time when, to quote Burke, the doctor must deal with an array of sophisters, economists, and calculators. The state, lay organizations, and others, claiming their pecuniary interests, are striving for hospital control and often the relegation of the physician to the status of an ordinary employee.

For the doctor the hour is already late. To regain his rightful authority he can no longer drift. Attempts have been made by ambitious organizations to induce legislatures to permit them to contract with hospitals for medical service, which would mean making the doctor their hired man, and depriving the patient of his right to select his physician.

Regardless of what we think, we are part of a new social order and we must not abdicate the authority that has made medicine great. Hospitals are an integral part of our work; we must not surrender control of them even though it means the assumption of pecuniary obligations that will deliver ourselves and the public from the grasping machinations of those who look upon hospitals as institutions for the development of power and profit. The doctor must save the hospital from the money motive if he would save himself. To be free he can do no less in spite of the nostalgic emotions he may experience when he contemplates a time, now past, when hospital business was limited to the essentials and when charity was the compelling motive.

P. R. Minahan

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« « « EDITORIALS » » »

Introducing the Guest Editorialist

A PRICELESS possession of medicine is the cooperative effort of physicians with lay leaders who appreciate the value of medical research and the advancement of preventive medicine. No medical problem has necessitated more public interpretation than the subject of cancer. Increased public awareness of the importance of early diagnosis has brought with it the willingness of outstanding Wisconsin men and women to assist with the solicitation of funds necessary for the furtherance of a program of lay education and cancer research.

Wisconsin is fortunate to have Folke Becker, president of the Rhinelander Paper Company, who is willing to devote his time and effort to the advancement of the cancer program in Wisconsin. Long prominent in industrial circles of the state Mr. Becker has given testimony of his social consciousness in many ways. In 1945, when the American Cancer Society called upon him to direct the Wisconsin cancer campaign he arranged his busy schedule to give the campaign the leadership required. A record collection of more than $70,000 resulted. Now, with an even higher goal set for Wisconsin, Mr. Becker has been called upon a second time and his acceptance as state campaign manager will contribute greatly to the attainment of goals set by the Committee on Cancer and the Field Army for the ensuing year.

Which Would You Rather Pay?

THE medical profession has long realized that the dread disease Cancer is our Number One Enemy. Briefly, this is what the people of Wisconsin are going to do about Cancer this year.

The Wisconsin Division of the American Cancer Society has as its goal in the Cancer fund-raising drive which commences April 1 $155,000, exclusive of Milwaukee County which is conducting a separate fund-raising campaign. This figure is more than twice as much as was raised last year. To meet this goal the committee whose responsibility it is to raise these funds must have the active cooperation and help of each physician in Wisconsin.

The drive for funds in Wisconsin is set up according to Medical Districts with an over-all campaign chairman for each district. In turn each county in the district has a county campaign manager. Under him the county is divided into cities, towns, and localities, each supervised by a live-wire, public-spirited gentleman. This is the skeleton organization. In addition to these men, many others are classified as workers and solicitors. They make the active person-to-person contact with potential donators.

In addition to this organization of men there is a similar group of women, the American Cancer Society Field Army for Wisconsin. The men's job is to solicit funds among all types of businesses. The women's task is to conduct door-to-door solicitations, letter campaigns, publicity, and general education about cancer. Every member of each cancer fund-raising committee works on a purely voluntary basis.

Here is how the doctors can help. If each one of you will give some of his time to assist these two crusader organizations, the fight against the gangster Cancer will be more successful and our primary job of saving lives will have been more complete.

The medical men will discover the cancer committees in Wisconsin are "on fire" with zeal and ambition. Their job is never finished, so when they ask you for help please give it to them.

The purpose of the campaign for funds to fight cancer is two-fold: to raise money and to educate Wisconsin people, to give them the facts about a disease which will kill over 4,500 men, women, and children in Wisconsin during 1946. Surely each sane, thinking individual will acknowledge this is a terrific toll. With early diagnosis, proper treatment, and care from 30 to 50 per cent of these victims can be cured.

What disposition is made of funds collected in Wisconsin? Forty per cent will be spent nationally on a program of research under the guidance of the National Research Council, and for educational and service programs to supplement those of Wisconsin. Sixty per cent of the money collected will be retained in Wisconsin for preventive education of the layman; for cancer clinics for the physicians and surgeons; and to provide for better hospital facilities, cancer detection clinics, modern x-ray equipment, more radium, more long-term hospital provisions for cancer patients, education of the public as to cancer danger signals and necessity of early diagnosis and treatment, and visiting nurse service for cancer patients.

This is a large order to fill. Wisconsin can do it, Wisconsin must do it, Wisconsin will do it. Cancer costs lives, cancer control costs money. Which would you rather pay?

Folke Becker

YOU WILL FIND IT HERE

Probably most physicians are familiar with the report of a corporation to its stockholders. When it comes to the State Medical Society of Wisconsin, the membership will find the report of activities and stewardship in *The Wisconsin Medical Journal.*

Outline reports of major committee activity are found in the Forum section, with detailed committee reports, well worth reading, appearing in the issue of the *Journal* immediately preceding the annual meeting of the House of Delegates. The active management of the affairs of the profession is vested in the officers and Council in the interim between sessions of the House. In the *Journal,* members will find detailed minutes of their meetings, and of the action taken.

In many organizations members may well ask: Where does my contribution to society affairs go? How is the dollar spent?

The profession may well take time to examine the annual budget of the Society which is printed in an early issue of the *Journal* following the annual January meeting of the Council. The budget is also distributed to all members of the House of Delegates prior to the annual meeting.

It is a good feeling to write an editorial such as this. And the Society stands ready to answer any questions on this subject on which members desire further information. It is the members' Society.

LET'S MAINTAIN OUR ADVERTISING!*

Most of our readers may be familiar with the fact that the great bulk of the advertising material carried in the *Journal* comes through the Cooperative Medical Advertising Bureau of the American Medical Association. In other words, a manufacturer who wishes to advertise his product in the various state journals has to deal with only one concern rather than with each individual state journal office. Obviously, this makes for efficiency and saves time and expense for both the commercial houses and the journal offices. Whether or not a manufacturer uses a state journal to advertise his product depends upon information he secures regarding the effectiveness of his advertising in the area served by that particular journal.

Our readers are also well aware that the greater the amount of advertising a journal can carry the less is the cost of the journal to the society and, indirectly, to each member. Futhermore, the advertisements accepted for the journals by the Cooperative Medical Advertising Bureau are for reliable products only, all of them Council-approved. This means that no advertisement appears in the *Journal* for a product upon which complete reliance cannot be placed.

One method commerical houses have of evaluating the effectiveness of their advertisements is by the number of responses they receive from readers where invitations are included to write for reference books, literature, or samples . . . We hope our readers are taking advantage of these invitations, and by doing so they will be helping the *Journal* to maintain a satisfactory volume of advertising.

Obviously, mutual benefit is to be secured through the brand of advertising carried in our *Journal,* but if this service to our readers is to continue as we should like to have it, it must be a cooperative proposition or else our advertisers will drop away.

* Reprinted from Journal of Iowa State Medical Society, October, 1945, page 408.

WHAT ARE THE FACTS ON CANCER?

While cancer is a reportable disease in Wisconsin, physicians quite generally have failed to make these reports except on death certificates. The reporting of terminal cases may be statistically important, but it does not in itself serve to give helpful information to the profession as to the incidence of the disease, the type of treatment patients are receiving in Wisconsin, the response to treatment, and many other facts which are medically important.

In order to determine with greater accuracy factors related to cancer in Wisconsin the Committee on Cancer of the State Medical Society has approved a simplified, standardized record form which may be used by the physician for the original clinical record in place of the usual hospital form. Contacts have been made with all hospitals in the state to secure their cooperation in using these record forms in order that a copy may easily be made by the record clerk for a separate file covering all cancer cases, to the end that valuable statistical information may be compiled from time to time on the state level.

There are, of course, many cases of cancer treated in clinics and in doctors' offices which do not require hospitalization. In order to make a complete study it will necessitate each physician's using the standardized record form, and keeping cancer records in a separate file in his office. At a later date the Committee on Cancer will contact each physician, as well as hospitals, to assemble statistics on a state-wide basis.

While cancer research is expected to open the door of discovery to a cure, a better understanding of the incidence of cancer and its early detection can save many lives while research studies are being conducted. Publicity has made the layman aware of the fact that carefully conducted physical examinations can often reveal cancer in its early curative stage. The fulfillment of this trust rests in the hands of every practitioner, who must acquire knowledge and skill of cancer detection.

It is hoped that during the ensuing years the Committee on Cancer will have an opportunity of presenting to the profession a series of postgraduate teaching courses, in the nature of lectures by outstanding national authorities and carefully planned demonstrations. Attendant to this program is that of more accurate reporting of cancer cases by physicians and hospitals alike.—W. S. B.

Physicians in Service

For many months material in this section was carried under the title of "The Nation at War." With physicians still entering service, with many returning to reestablish themselves in civilian practice, and with many planning to continue in service for an indefinite time, it is the decision of the *Journal* to continue the section under a more timely title.

Military Notes

L. G. KINDSCHI

Dr. Leslie G. Kindschi, former Monroe physician, has been advanced to the rank of lieutenant commander at Great Lakes Naval Training Station, where he has served since his return from twenty months' sea duty in the Pacific.

Commander Kindschi entered the service August 18, 1943.

Captain F. B. Vande Loo, Brillion, is on terminal leave from the Army Medical Corps. He entered the Army December 3, 1942, and will be officially discharged April 22, 1946.

Lieutenant Eugene E. Eckstam, Madison, now stationed in Manila, with the Navy Medical Corps, writes: "I expect to be in Manila for at least four more months. It is rather a nice city to live in even though it is damaged by war.

"I have the very officious title of liaison medical officer. But actually I just go around to the Army hospitals and try to keep our base medical office informed of Navy patients in Army hospitals and plan their disposition in case of evacuation or transfer. It's entirely administrative. I also have additional duties as a member of a general court martial board (One of five members). We've had 2 cases so far and more to come.

"It sounds as if I'm fairly busy but actually I'm not . . . I believe there is no further use for any of the Army or Navy staying here. We are only supporting ourselves and doing nothing. The quicker we leave the better it will be for all. We have to get out of here by July because the Philippines are getting their independence then.

"The two dispensaries (Navy) each had 7–8 doctors a week ago. Since then, 3 have gotten orders for other stations including China. But there are still so many that we fall over each other. 90 beds and 12 doctors!! Read your newspapers about holding doctors in the service needlessly and believe them. It is true all over out here.

"How do I stand on points? As of 1 January, I have 39 points and need 51. As of 2 March I'll have 40½ and will need 49. I do not expect to be released till June, perhaps May, and I have no idea when I'll get home either."

Lieutenant Commander William B. Hildebrand, former Menasha physician, is stationed on Okinawa with Marine Air Group 14. He is a naval flight surgeon, having graduated from the school of aviation medicine, with flght training, in 1944.

He writes: "I am very happy to report that I shall be available for discharge about the middle of March and hope to be back in Menasha soon after that. It cannot be too soon. After knocking around the world for the past three years I still cannot find anything to compare with the Fox River valley."

When he returns to Menasha, Doctor Hildebrand will be associated in practice with his brother, Dr. George B. Hildebrand, formerly of Ann Arbor. The latter recently received his discharge from the Army Medical Corps, having served in the Pacific for twenty-three months. Commander William Hildebrand entered the service October 25, 1943.

SN-7618 EFFECTIVE ANTI-MALARIAL DRUG

The new anti-malarial drug, SN-7618, which the Army Medical Department played an important part in developing, has been found to be superior in many ways to quinine or atabrine, according to a recent announcement by the Office of The Surgeon General.

Studied in collaboration with the Interservice Board for the Coordination of Malarial Studies, SN-7618 was tested in experiments at Harmon General Hospital, Longview, Texas, and Moore General Hospital at Swannanoa, North Carolina, in addition to some overseas theaters of operations.

Designed to obtain information on the value of the drug in controlling the symptoms and fever occurring in acute attacks of malaria, these studies included the observation of more than 600 malaria-stricken soldiers, who were administered different amounts of the drug in from one to seven days. When notations had been made of symptoms such as the passing of the fever and the disappearance of malarial parasites from the blood stream, the patients were kept in the reconditioning section to determine the possibilities and time interval for relapse.

Returning Veterans

W. J. BLECKWENN

Colonel William J. Bleckwenn, Madison, in service for more than five years, is on terminal leave from the Army Medical Corps. He will resume his duties as professor of neuropsychiatry at the University Medical School and assistant director of the Wisconsin Psychiatric Institute.

Leaving Madison January 13, 1941, Colonel Bleckwenn was in command of the 135th Medical Regiment which trained in Mississippi for a year. In March of 1942 he went to Australia.

After serving in New Guinea, Colonel Bleckwenn was named surgeon for all bases north of the Australian mainland.

Returning to the United States in June, 1944, he was assigned as neuropsychiatric consultant of the Sixth Service Command in Chicago.

Captain Albert J. Boner has resumed his medical practice in Madison after more than three years in the Army Medical Corps. Doctor Boner entered the Army December 12, 1942, and was released from active duty December 22, 1945. His terminal leave ends March 20, 1946.

Captain Boner served as division neuropsychiatrist and consultant in internal medicine for the Sixth Armored Division of the 3rd Army.

Doctor Boner is an instructor in clinical medicine at the University of Wisconsin Medical School.

Lieutenant Commander Paul Campbell, Waukesha, has returned to his medical practice there after serving with the Navy for forty months.

Doctor Campbell entered service September 28, 1942, and spent thirteen months with amphibious forces in the Pacific. He received his discharge January 8.

Captain R. E. Christiansen has resumed his medical practice in Superior. Doctor Christiansen has been serving with the Army Medical Corps since 1942. In September, 1944, he left for overseas duty and served with the 112th Evacuation Hospital of the 7th Army, and with the 10th Field Hospital in France, Germany, and Austria. After V-E Day Doctor Christiansen was assigned to the Dachau concentration camp.

The doctor was stationed at Camp Beale, California, from the time of his return to the United States until his discharge. His terminal leave ends March 5, 1946.

L. J. KEENAN

Lieutenant Commander Lawrence J. Keenan, Fond du Lac physician who recently returned after being released from active duty with the Navy, has received the commendation ribbon for meritorious service in connection with the early development of Guam as a senior medical officer of the 23rd naval construction battalion. The citation accompanying the award reads as follows: "Working day and night under difficult conditions he succeeded in the elimination of all sources of contagion. His careful attention given to each man in the battalion kept the maximum number of men working on vitally needed projects such as the Orote field activities and the inner harbor development. His professional skill, leadership, and devotion to duty were an inspiration to all with whom he served and were in keeping with the highest traditions of the U. S. Naval service."

Doctor Keenan entered the service January 18, 1943, and spent three months examining officer candidates at stations in Chicago, St. Louis, and Cincinnati. He was then assigned to open the V-12 program at Marquette University; he remained there seven months.

Joining the 23rd naval construction battalion in Camp Parks, California, Commander Keenan organized it after its return from fourteen months in the Aleutians. He went overseas with the battalion in July, 1943, serving at Pearl Harbor and Guam.

Captain Harold J. Kief has returned from military service to resume his medical practice in Fond du Lac. Doctor Kief was discharged following service with the Army Medical Corps which included two years in the South Pacific with the 32nd division.

Doctor Kief practiced medicine in Fond du Lac for five years before entering the service July 1, 1942, and was an associate staff member of St. Agnes Hospital.

Dr. Henry Kleinhanz has opened offices in Whitewater, following his return from military service. He entered the service in 1942 and served in England.

Major Waldo B. Dimond of Madison has returned from the Army Medical Corps and has resumed his medical practice.

C. A. FOSMARK

Captain Carl A. Fosmark, Madison physician and surgeon, who has been serving as a flight surgeon with the Army Air Forces for three and one-half years, is practicing again after receiving his discharge in December.

Doctor Fosmark was commissioned August 18, 1942. After graduating from the school of aviation medicine at Randolph Field, and the medical school of chemical warfare, Edgewood Arsenal, Maryland, he was assigned to B-24 and B-29 groups as squadron flight surgeon. Serving twelve months on Guam, Captain Fosmark received battle stars for the air war of Japan, the Mariannas campaign, and the Eastern Mandated Islands campaign.

Captain John C. Frick has been released from active service with the Army Medical Corps and has returned to private practice in Waukesha.

Doctor Frick entered the service August 18, 1942, and will be officially discharged March 19.

Lieutenant Commander Rocco S. Galgano, recently placed on terminal leave from the Navy Medical Corps, has returned to Delavan and will be associated with Drs. **N. F. Crowe, T. L. Jacobson,** and **H. J. Kenney.**

Doctor Galgano graduated from the Marquette University Medical School and interned at St. Joseph's Hospital, Milwaukee. He was a resident physician at St. Michael's Hospital, Milwaukee, when he entered active service with the Navy in September, 1942.

Commander Galgano served with the 1st Marine Division on Guadalcanal, Australia, New Guinea, New Britain, and the Russell Islands. He returned to Great Lakes in August, 1944; was promoted to lieutenant commander in October, 1945; and began his terminal leave January 5, 1946. Doctor Galgano will be officially discharged March 19, 1946.

Lieutenant Halbert Gulbrandsen, last Viroqua physician to return from overseas, is now on terminal leave from the Army Medical Corps. Since returning from the South Pacific, he has been hospitalized in New York.

Doctor Gulbrandsen entered the service September 9, 1942.

Lieutenant Commander Chalmer Davee has received his discharge from the Navy and has resumed his practice of medicine and surgery in River Falls. Doctor Davee entered the service April 19, 1943.

D. D. RUEHLMAN

Lieutenant Commander David D. Ruehlman, Monroe physician and surgeon, has returned to practice. He has served in the Navy for thirty months, and is on terminal leave until March 15.

Commander Ruehlman entered the Navy August 8, 1943, trained on the west coast, and went overseas with a Marine Corps amphibious unit in December of that year. After returning to this country in the spring of 1945, he again went on sea duty in July—serving with the 3rd Amphibious Force on Okinawa, and in Tokyo.

Since his return, the doctor has been stationed at Great Lakes, the University of Wisconsin, and at the Naval Ordnance Base, Indianapolis.

Colonel E. P. Ludwig, discharged January 11, has resumed active partnership with **Dr. A. W. Boslough** in Wausau. First Wausau physician to enter the service in World War II, Doctor Ludwig joined the Army Medical Corps January 20, 1941.

Colonel Ludwig served with the 135th Medical Regiment at Camp Shelby, Mississippi, until March, 1942, when he sailed for Australia. They later moved to New Guinea, then left in October, 1944, to participate in campaigns in the Philippines, including Leyte.

Upon his return to the United States, Colonel Ludwig served as director of reconditioning at the 5,500-bed convalescent hospital at Camp Butner, North Carolina.

Captain Lyman W. Picotte, Chippewa Falls, announces the reopening of his office, following his release from active duty with the Army Medical Corps on January 12.

Doctor Picotte served as medical officer in charge of the disciplinary training center at Casa Blanca, French Morocco, and as commanding officer of the 875th Medical Hospital Ship "Platoon."

For the last six months before his release, Doctor Picotte was in charge of the Dependency Clinic for all Army wives and dependents attached to the San Francisco port of embarkation.

Doctor Picotte entered the service July 22, 1943.

Dr. Melvin V. Schlaak, Madison, was recently promoted to lieutenant colonel. Colonel Schlaak, a member of the department of radiology at Wisconsin General Hospital, is now on terminal leave following five years of service in the Army. He left Madison with the 135th Medical Regiment of the National Guard in January, 1941.

LIBRARY OF THE COLLEGE OF PHYSICIANS

O. H. HANSON

Now on terminal leave from the Navy after 32 months' service, **Lieutenant Commander Oscar H. Hanson** has resumed his practice of medicine and surgery in Fort Atkinson, in association with **Drs. Will Young and J. J. Harris.**

Doctor Hanson served twenty-two months overseas with the 2nd Marine Division; he was awarded battle stars for the Saipan, Tinian, and Okinawa campaigns.

Doctor Hanson practiced in Fort Atkinson for ten years before entering the service June 28, 1943.

Commander Earl J. Hatleberg is associating in medical practice with his brother, **Dr. C. N. B. Hatleberg,** in Chippewa Falls.

Doctor Earl Hatleberg entered service with the Navy April 7, 1942, and served in the Pacific Theater as chief of surgery of an evacuation hospital attached to the 28th Regiment of the 5th Marine Division. He later served as regimental surgeon when the unit served as an occupation force on Kyushu.

Doctor Hatleberg graduated from Rush Medical College, interned at the Swedish Covenant Hospital, Chicago, and practiced in Rice Lake for five years before entering the service. He was officially discharged February 12, 1946.

Commander Edward D. Hudson, Lake Geneva physician, is home after three years in the Navy. He has been stationed on the aircraft carrier USS Biaroko, serving in the Pacific area.

Following his discharge, Commander Hudson will resume his medical practice in Lake Geneva. He entered the service March 26, 1943.

Lieutenant Commander Russell Jackson, Jr., recently discharged from the Navy after three and one-half years of service, has returned to medical practice in Madison and Sun Prairie, in association with the Jackson Clinic.

Commander Jackson spent more than two years overseas, taking part in several invasions including that of Sicily.

Doctor Jackson entered the service July 14, 1942.

Major H. M. Levin has reopened his office in Darien. Doctor Levin spent two and one-half years in the service, two of them in the South Pacific. He entered the service June 3, 1943, and was discharged March 3, 1946.

E. ALLEN MILLER

Major E. Allen Miller, Watertown physician and surgeon, has received his discharge from the Army Medical Corps, and will resume practice with **Dr. W. C. Becker,** after a vacation.

Doctor Miller entered the service June 3, 1943, and spent nineteen months in the China-Burma-India Theater. A flight surgeon with the headquarters squadron of the 10th Air Force, Major Miller was stationed in Burma until the completion of that campaign. He spent considerable time in Assam, India.

A portable hospital unit, reports the doctor, with the best equipment was used by the squadron. When the time arrived to move to an advanced base, cargo planes carried the entire hospital to the next station.

Major Miller's work involved considerable flying, including many trips over the "Hump," and trips to various places in India, Burma, and China. He will be officially discharged March 29, 1946.

Dr. Howard W. Christensen, recently returned from service, has resumed his medical practice in Wausau.

Requesting that his address be changed to Wauwatosa, his home, **Lieutenant Colonel Earl A. Clasen** writes: "I am now on terminal leave until 11 March 46. I served my entire Army career at the New Orleans Port of Embarkation as Post Surgeon of the different camps under the port. It was very interesting to see many of the men coming through here, within the last several months, whom we staged in 1942 and 1943."

Doctor Clasen entered the service May 22, 1942.

Major J. J. LaBreche has opened his office for the practice of medicine and surgery in Stanley. Discharged January 31, Doctor LaBreche served in the Army Medical Corps for thirty-one months.

After serving at various stations in this country, Major LaBreche went overseas in May of 1944. He was a member of the 22nd General Hospital staff at the 802nd Hospital Center, Blandford, England; Camp Surgeon at Camp St. Louis in Rheims, France; served with the 1115th Combat Engineer Group, a unit of the 7th Army; the 2nd Replacement Depot at Namur, Belgium; the 4th Medical Detachment at Le Havre; and was transport surgeon on the Pittston Victory on his voyage home.

Doctor LaBreche was located in the Stanley area for about five years previous to his military service.

J. P. MALEC

Major John P. Malec, Madison, has returned from the Army Medical Corps and resumed his medical practice in association with **Drs. Donald M. Britton** and **Hance F. Haney.**

Doctor Malec, a general surgeon, was stationed at Chanute Field, Truax Field, and in England. He entered the service August 4, 1941, and was discharged December 23, 1945.

Doctor Britton is still in the service, stationed at Woodrow Wilson General Hospital, Staunton, Virginia; upon his discharge he will join the group, practicing obstetrics and gynecology.

Doctor Haney, on the faculty of the University of Oregon Medical School for the past nine years, will practice internal medicine. He is a former Madison resident.

Major Bernard C. Dockendorff is at home in Arcadia on terminal leave. He entered active service May 6, 1942, and holds the Asiatic–Pacific, American Theater, and Victory ribbons.

Doctor Dockendorff served at the following stations: chief of septic surgery, station hospital, Camp Grant; assistant chief of surgical service, station hospital, Camp McCoy, regional hospital, Camp Shelby, Mississippi; chief of general surgery, Tinney General Hospital, Thomasville, Georgia; chief of septic surgery, 303rd General Hospital, Tinian; and chief of general surgery, 74th General Hospital, Tinian. On Tinian, casualties from the battles on Iwo Jima and Okinawa were cared for. Installations were of a permanent nature and facilities for care of the wounded were good.

Major Dockendorff will be officially discharged March 29, 1946.

Returned from three years' service with the Army Medical Corps, **Captain Norman C. Erdmann** has resumed his medical practice in Manitowoc.

Doctor Erdmann entered active service in 1943, and served a tour of duty in a west coast general hospital treating casualties from the Aleutian campaign. He then went to the South Pacific.

Upon his return to this country he aided in the preparation of medical units, destined for foreign duty, at Camp Ellis, Illinois.

Assigned for the past year to the Percy Jones General Hospital, Battle Creek, Michigan, Doctor Erdmann had charge of the Officers Neurosurgical Section. The hospital specializes in neurosurgery, orthopedic surgery, amputations, plastic, eye, and chest surgery, and is one of the Army's largest.

Doctor Erdmann wears the American Theater, Asiatic Pacific, Meritorious Service, and Victory ribbons.

W. J. SCHUTZ

Captain Weston J. Schutz and **Captain Arthur P. Klotz**, both on terminal leave from the Army, are now associated with the Cantwell–Peterson Clinic in Shawano.

Doctor Schutz entered the Army Air Forces August 4, 1942, and was graduated from the school of aviation medicine at Randolph Field on December 17, 1942. After serving a year and a half in the states, he joined the 9th Air Force in Europe, where he served as a flight surgeon for two years. Doctor Schutz had practiced general medicine in Shawano for a year before entering the Army. He will be officially discharged March 10, 1946.

Doctor Klotz entered the Army in 1942, and served three years in the European Theater of Operations as battalion surgeon with the 3rd Army. He practiced in Cincinnati and Gillett before entering the service.

Lieutenant Colonel Stevens J. Martin, Viroqua, writes: "I would like to inform you and other friends in the states that after four years and seven months of active duty, I was separated from the service on the 29th of January, 1946. I am now at home trying to orient myself to civilian life and enjoying the first part of my 111 days of terminal leave.

"My service was spent entirely at Tilton General Hospital, Fort Dix, New Jersey where I organized the first School of Anesthesiology in the Army and directed it until my separation. Nineteen classes of three months duration were held for a total of 92 medical officer students. In a hospital that finally grew to a capacity of over 5,000, this was an interesting and valuable experience. I had the pleasure of seeing many Wisconsin physicians. They, as well as I thoroughly enjoyed and appreciated your Journal with its timely comments, summaries of your activities and news from overseas men. We are grateful to you."

Doctor Stevens entered the service July 1, 1941.

Lieutenant Colonel Benedict R. Walske, physician and surgeon, announces the opening of his office in Arcadia. He is on terminal leave from the Army Medical Corps, having served since February 5, 1941.

Before entering the Army, Doctor Walske was located at Independence; he was also on the surgical staff of St. Joseph's Hospital, and is again associated with it.

Lieutenant Robert C. Strand is resuming his practice in Eau Claire, having completed postgraduate study at the University of Chicago. Doctor Strand was released from active service with the Navy Medical Corps last fall. He entered the Navy January 10, 1941, and served aboard a combat ship in the Pacific Theater for ten months. Upon his return he was assigned to naval hospitals in California and Florida.

Dr. John M. Usow, Milwaukee, who has resumed his private practice of neurology and psychiatry, has been awarded the Bronze Star Medal for meritorious achievement in connection with military operations in the Mediterranean Theater from 1 December, 1942, to 8 May, 1945. The citation accompanying the award read:

"JOHN M. USOW—1697732, Major, Medical Corps, 114th Station Hospital, for meritorious achievement in connection with military operations in the Mediterranean Theater from 1 December 1942 to 8 May 1945. As one of the pioneer neuropsychiatrists in the Mediterranean Theater of Operations, Major Usow personally treated a majority of the psychiatric casualties evacuated from the Tunisian front, most of whom were returned to useful duty in the theater, and in addition was responsible for the establishment of the first medical board for the disposition of such patients. By his great energy and superior professional ability, Major Usow was responsible personally for the return to duty in the theater of hundreds of psychiatric casualties and contributed in a large measure to the formulation of standards, policies and methods resulting in the return to duty of thousands of other such patients. By his actions and by his devotion to duty, he played a leading role in conserving the strength of the command and has reflected credit upon himself and the Medical Corps of the Army of the United States. Entered service from Milwaukee, Wisconsin."

Lieutenant Commander James E. Conley is at home in Watertown on terminal leave from the Navy Medical Corps. He recently returned from Japan aboard the USS Southampton, to which he had been assigned as surgeon for the past seventeen months.

Doctor Conley was commissioned in August, 1942, and was assigned to Chelsea Naval Hospital in Boston. In 1943 he went to the Naval Air Base Hospital in Argentia, Newfoundland.

After returning to the United States in 1944, Commander Conley spent several months at a naval hospital in Quonset Point, Rhode Island.

In July, 1944, Doctor Conley was assigned to Charleston, South Carolina, to precommissioning detail and duty aboard the USS Southampton, an attack transport ship. The ship participated in the initial assaults on Iwo Jima, transporting assault troops and equipment, and evacuating casualties as a hospital ship.

At the conclusion of his terminal leave Doctor Conley will practice surgery in Milwaukee.

PROMOTIONS

Dr. Leslie G. Kindschi, Monroe, to lieutenant commander.

Dr. Carroll R. Olson, Milwaukee, to captain.

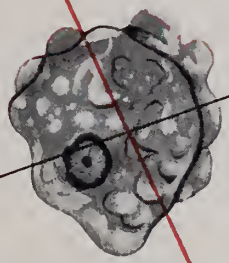
Dr. Melvin V. Schlaak, Madison, to lieutenant colonel

Recent Releases From Service*

Physicians and Location	*Date Discharged*
Anderson, G. H., Stevens Point	January, 1946
Bear, N. E., Monroe	February, 1946
Beffel, J. M., Milwaukee	January, 1946
Benjamin, H. B., Wauwatosa	March, 1946
Bentley, J. E., Madison	January, 1946
Black, S. B., West Allis	December, 1945
Boner, A. J., Madison	March, 1946
Callaghan, D. H., Hayward	March, 1946
Carl, E. F., Milwaukee	January, 1946
Christiansen, R. E., Superior	March, 1946
Christianson, H. B., Superior	February, 1946
Clasen, E. A., Milwaukee	March, 1946
Cole, D. F., Ripon	November, 1945
Conway, J. P., Milwaukee	January, 1946
Currer, P. R., Wauwatosa	February, 1946
Davies, Gwilym, Waukesha	March, 1946
Dockendorff, B. C., Arcadia	March, 1946
Donath, L. H., Milwaukee	December, 1945
Falk, V. S., Wauwatosa	February, 1946
Frick, J. C., Waukesha	March, 1946
Fulton, J. W., West Allis	February, 1946
Galgano, R. S., Delavan	March, 1946
Gregory, L. W., Manitowoc	December, 1945
Hammond, R. W., Manitowoc	February, 1946
Hansher, Ervin, Milwaukee	March, 1946
Harris, J. J., Fort Atkinson	December, 1945
Henke, S. L., Eau Claire	January, 1946
Hirschboeck, J. S., Milwaukee	December, 1945
Holbrook, A. A., Milwaukee	February, 1946
Houghton, W. J., Milwaukee	September, 1945
Huth, M. F., Baraboo	January, 1946
James, W. D., Oconomowoc	January, 1946
Jelenchick, E. J., Milwaukee	March, 1946
Johnson, H. W., Milwaukee	March, 1946
Johnston, T. L., Milwaukee	December, 1945
Jorris, E. H., Madison	February, 1946
Joyner, T. H., Oregon	March, 1946
Kelley, J. F., Janesville	February, 1946
Kelly, W. J., Potosi	December, 1945
Kincaid, C. K., Eau Claire	February, 1946
Konz, S. A., Appleton	December, 1945
Landis, R. V., Appleton	November, 1945
Lustok, M. J., Milwaukee	January, 1946
Macht, A. J., Milwaukee	February, 1946
Markson, L. S., Milwaukee	February, 1946
Maser, J. F., Milltown	March, 1946
Mauerman, W. J., Beloit	March, 1946

* Members of the State Society listed in boldface.

in amebiasis:



symptomatic . . . asymptomatic

Barr[1] states: ". . . it is just as important to treat properly the symptomless 'carrier' of this parasite as to treat the patient suffering from amebic dysentery."

Stitt, Clough and Clough[2] report, "The disease may be symptomless . . . These mild or symptomless cases have been shown to outnumber greatly the cases with clinical dysentery. They constitute the carriers or 'cyst-passers'."

DIODOQUIN (5, 7-diiodo-8-hydroxyquinoline) is safe to use even in suspected cases of amebiasis. Nonirritating, nontoxic—Diodoquin has been found promptly destructive to protozoa in amebiasis and Trichomonas hominis (intestinalis).

DIODOQUIN

ACCEPTED AMERICAN MEDICAL ASSN. Council on Pharmacy and Chemistry

is the registered trademark of G. D. Searle & Co. Chicago 80, Ill.

1. *Barr, D. P.: Modern Medical Therapy in General Practice, 2:1830, Baltimore, Williams & Wilkins Company, 1940.*
2. *Stitt, E. R.; Clough, P. W., and Clough, M. C.: Practical Bacteriology, Haematology and Animal Parasitology, ed. 9, Philadelphia, P. Blakiston's Son & Co., 1938, pp. 410-412.*

SEARLE *Research in the Service of Medicine*

Prescribe Journal-advertised products and you prescribe the best.

Physicians and Location	*Date Discharged*
McDonald, R. E., Milwaukee	December, 1945
Midelfart, Peter, Eau Claire	February, 1946
Millard, A. L., Marshfield	December, 1945
Miller, E. A., Watertown	March, 1946
Morrison, J. T., New York	March, 1946
Muenzner, R. J., Jr., Milwaukee	November, 1945
Nowack, L. W., Watertown	February, 1946
Ottenstein, H. H., Milwaukee	February, 1946
Peters, B. J., Milwaukee	November, 1945
Petersen, G. W., Neenah	August, 1945
Presti, A. A., Milwaukee	December, 1945
Ricciardi, I. J., Milwaukee	March, 1946
Rice, M. G., Stevens Point	January, 1946
Ross, F. A., Milwaukee	January, 1946
Ruehlman, D. D., Monroe	March, 1946
Ryan, W. A., Milwaukee	January, 1946
Thomas, C. C., Milwaukee	October, 1944
Schutz, W. J., Shawano	March, 1946
Seward, L. J., Berlin	December, 1945
Shapiro, H. L., Prairie du Chien	December, 1945
Simenson, R. S., Valders	December, 1945
Skow, G. D., Racine	October, 1945
Usow, John, Milwaukee	February, 1946
Vetter, E. W., Randolph	February, 1946
Wear, J. B., Madison	February, 1946
Wegmann, G. H., Milwaukee	February, 1946
Wilets, J. B., Milwaukee	December, 1945
Williams, E. B., Oshkosh	November, 1945
Williamson, C. S., Green Bay	March, 1946
Wyman, J. F., Milwaukee	February, 1946
Zimmerman, F. H., Watertown	March, 1946

VETERAN PHYSICIANS' EXCHANGE

This page will be devoted to a classified section, open without charge to: (a) veteran members desiring location and (b) other members having professional openings suitable for men returning from military service.

LOCATIONS WANTED

LOCATION WANTED: Young orthopedist, completely trained in both reconstructive and traumatic surgery, desires industrial or group practice connection in or near Milwaukee. Available after July 1, 1946. References exchanged on request. Address No. 100 in care of the Journal.

LOCATION WANTED: 39 year old physician with 3-year residency in General, Gyn., and Traumatic Surgery, 4½ years general practice, and 4½ years in Army hospitals, desires location in a northern or central state community of 2,000 to 25,000, with hospital facilities. Would consider association with established practitioner. Available immediately. Address No. 101 in care of the Journal.

WANTED: Location or association with physician in S. W. United States. Age 39 years. Class A graduate. Ten years active civilian and military experience, including surgery. Address No. 102 in care of the Journal.

LOCATION WANTED: General practitioner, 36, will purchase practice, home, etc.; available May 1, 1946. Can arrange personal interview immediately. Address No. 103 in care of the Journal.

LOCATION WANTED: Pediatrician, 32, protestant, married, graduate Class A school, 4 years hospital training, eligible for certification by American Board, Wisconsin state license, on terminal leave after 3½ years naval service, desires location or association with practice limited to pediatrics. Available after March 15. Address No. 111 in care of the Journal.

DESIRE GENERAL PRACTICE in town 5,000–25,000 anywhere in Wisconsin with good hospital facilities. Have much of own medical equipment from previous general practice. Over 3 years service in U. S. Public Health Service with wide variety of general practice especially in internal medicine, general surgery, psychiatry, and eye work, especially refractions. Must have housing for wife and three children. Would consider partnership with older doctor who does own general surgery. Would also consider joining clinic. Address No. 112 in care of the Journal.

WANTED ASSOCIATION with a clinic group or another orthopedist. 3 years residency completed in orthopedics in mid-west university. 1st part of American Board of Orthopedics exam passed. Available in June. Address No. 113 in care of the Journal.

ASSISTANCE WANTED

PHYSICIAN WANTED: Village of 1,200. Fourteen miles to three hospitals. No competition. Farming community. Office space available. Address No. 108 in care of the Journal.

WANTED: Man to take over my home in town of 500. All modern, cost $14,000; will sell for $6,000. Oil burner, 2-car garage, redecorated. Modern office with $2,000 improvements; 8 rooms. Office rent $30, ground floor. Doctor to run office, and work with a three-man clinic 7 miles away in town of 4,000 with modern hospital. Clinic to be formed and new building to be built soon. Address No. 104 in care of the Journal.

WANTED: Southern Wisconsin Clinic needs energetic M. D., general work, surgical, obstetrical, medical and industrial. Good opportunity for permanent position. Address No. 105 in care of the Journal.

PHYSICIAN WANTED: About March 1 to take over a well established practice in a prosperous lumbering and farming community. Fully equipped office with x-ray equipment and a heated residence furnished. No cash outlay required when starting. Address No. 106 in care of the Journal.

ASSISTANT WANTED: General practice, surgical training, with prospective partnership. Address No. 107 in care of the Journal.

WANTED: Assistant in a large general surgical and medical practice by physician in city of two thousand, having a 20-bed community hospital, in prosperous farming community in midwestern Wisconsin. Must be willing to do some surgery and obstetrics. Full partnership after one year, if conditions satisfactory. Salary determined by amount of experience. Fully equipped office including fluoroscope, x-ray, BMR, EKG, etc. Address No. 109 in care of the Journal.

DOCTOR WANTED: The doctor who practiced here for over 50 years recently died. There is a modern house, water, bath, etc.; excellent double garage, can be heated; office attached to house, small waiting room and small drug room, no modern equipment. Good will of the community goes with opportunity. Address No. 114 in care of the Journal.

ASSOCIATE DESIRED: To do internal medicine and pediatrics. Also required to assist in major surgery. Excellent opportunity in a good community which has a well-equipped 60-bed hospital. Applicants must have had postgraduate training in internal medicine or pediatrics. Address No. 115 in care of the Journal.

(Continued on page 338)

Nine physicians were among 225 upper income patients found guilty of diets wanting in one or more vitamins. Low-vitamin diets are not restricted by income or by intelligence.[2] Greater assurance of adequate vitamin maintenance is available in potent, easy to take, and reasonably priced Upjohn vitamin preparations.

1. New England J. Med. 228:118 (Jan. 28) 1943.
2. J. A.M.A. 129:613 (Oct. 27) 1945.

Upjohn
KALAMAZOO 99, MICHIGAN

FINE PHARMACEUTICALS SINCE 1886

UPJOHN VITAMINS

Prescribe Journal-advertised products and you prescribe the best.

ASSISTANCE WANTED—Continued

WANTED YOUNG PHYSICIAN: With ability to do general surgery, to be associated with busy general practitioner, in central Wisconsin area. Population of city over 2,000. Unlimited opportunity for right man. Address No. 116 in care of the Journal.

WANTED ASSISTANT leading to partnership; busy general practice, considerable obstetrics and gynecology. Central Wisconsin city of 35,000 with excellent hospital facilities. Prefer young married doctor. Salary open. Address No. 118 in care of the Journal.

OPPORTUNITY: In town of 10,000 for returning veteran with some training in internal medicine to joint clinic in department of dermatology and allergy, to work chiefly with general allergies. Opening for permanent position; applicants for temporary position also considered. Clinic composed of 16 doctors, all members of respective specialty boards. Address No. 119 in care of the Journal.

WANTED: Someone who is planning to specialize in the future and is anxious to earn some money before going on to school. The work would consist of that of a general practitioner such as home calls, office, practice, etc. and would be well paid. This will be purely temporary and we are not interested in anyone planning to locate permanently in this community. Address No. 120 in care of the Journal.

FOR SALE OR LEASE: Retiring physician's modern house including five-room fully equipped office in thickly populated part of Milwaukee. Fine opportunity for young energetic physician with surgical and general medical experience. It is also suitable for a group. Rental income from the property pays taxes and upkeep. The sale requires $10,000 cash—balance easy terms. Would lease ONLY the office to a suitable party. Address No. 121 in care of the Journal.

FOR SALE: $28,000 property; four apartments besides own 5-room and 4-room offices. Garage in basement. Located on corner of 18th and Wells Streets in heart of Milwaukee medical center. Children's Hospital and Curative Workshop near; one block to Deaconess, three blocks to Marquette University, five blocks to Milwaukee Hospital, Mt. Sinai, etc. Ten blocks to heart of city. Could use dentist with myself or whoever buys the place, or splendid clinic location. Address No. 110 in care of the Journal.

VETERAN PHYSICIANS: This is a strategic time to enter public health. State Board of Health has 2 openings for physicians with executive ability as directors of the tuberculosis and venereal disease divisions. Salary $4,800 to $5,400 plus necessary traveling expenses, Madison headquarters. 5 district health officers also needed. If you were under 40 when entering the armed services and can otherwise qualify, write Dr. Carl N. Neupert, State Health Officer, Madison 2, Wisconsin.

HELP WANTED: State hospitals at Mendota and Winnebago and colonies and training schools at Chippewa Falls and Union Grove are in need of doctors, nurses, social workers, technicians, and other personnel. If interested contact the superintendents, or Dr. W. J. Urben, State Department of Public Welfare, 128 South, State Capitol, Madison.

WANTED: Staff physician at sanatorium approved for tuberculosis residency. Beginning salary $250–$300, less modest maintenance deduction. One position open July 1, another probable the last of March. Wisconsin licensure required. Person must have good professional and personal qualities. Write Superintendent, Wisconsin State Sanatorium, Statesan, Wisconsin.

WANTED: Returning veteran for general work in town of 5,000. General hospital and complete office available. Address No. 117 in care of the Journal.

For additional classified advertisements, see the Physicians' Exchange, page 366

Letters to the Editor

WILL C. BRAUN DEDICATION

Dear Sir: "All of us at the American Medical Association offices were delighted with your tribute to Mr. Braun, which we read in *The Wisconsin Medical Journal* . . . After having been closely associated with Mr. Braun for some twenty-five years, I feel that he richly deserves all of the good things you were kind enough to say about him."

Very sincerely yours,
(Signed) OLIN WEST
Secretary and General Manager, The American Medical Association

Dear Sir: ". . . you have done a fine job by getting out your own dedicatory issue."

Sincerely yours,
(Signed) MORRIS FISHBEIN
Editor, The Journal of the American Medical Association

Dear Sir: ". . . the dedication to Will Braun in *The Wisconsin Medical Journal* . . . was appreciated by me and I think it was a kindly thing for the *Journal* to do."

Sincerely,
(Signed) ROGER I. LEE
President, The American Medical Association

Dear Sir: "I think this is a lovely gesture. Bill Braun is one of the finest men it has ever been my pleasure to know, and he certainly did a grand job for American medicine. I admire him very much and am pleased to count him among my friends. Your tribute was great."

Sincerely yours,
(Signed) HERMAN L. KRETSCHMER
Past-President, The American Medical Association

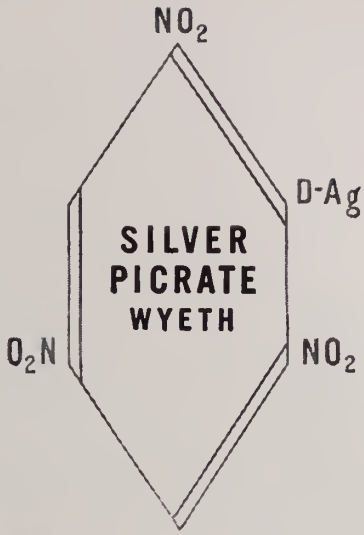
Dear Sir: "Thanks for . . . allowing me to read your splendid tribute to a splendid man. There is no question that the AMA is deeply in the debt of this fine outstanding citizen whose services through many years have added greatly to all organization efforts.

"I think it is splendid that *The Wisconsin Medical Journal* is dedicating an issue to him."

Very truly yours,
(Signed) FRED W. RANKIN
Past-President, The American Medical Association

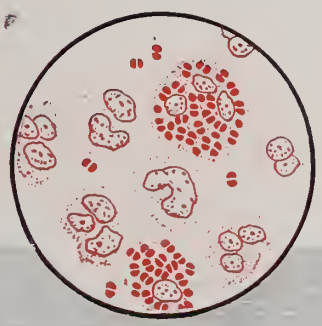
PICRAGOL

TRADE-MARK



PICRAGOL is an effective agent in the treatment of urethritis and vaginitis. Its specific action is especially valuable for the control of trichomoniasis or moniliasis of the vagina and for trichomonas infections of Bartholin's or Skene's glands.

PICRAGOL CRYSTALS, Bottles of 2 grams. • COMPOUND PICRAGOL POWDER, Silver Picrate Wyeth, 1 per cent, in a kaolin base. Packages of six 5 gram vials. • VAGINAL SUPPOSITORIES PICRAGOL, Silver Picrate Wyeth, 0.13 grams, in a boroglyceride-gelatin base. Packages of 12 • VAGINAL SUPPOSITORIES PICRAGOL, *for infants*, Silver Picrate Wyeth, 65 mg., in a boroglyceride-gelatin base. Packages of 12.



WYETH INCORPORATED • PHILADELPHIA 3 • PA.

Prescribe Journal-advertised products and you prescribe the best.

News Items and Personals

Course in Mothercraft Approved

A new course in "Mothercraft," approved by the Manitowoc County Medical Society, began Wednesday, January 23, at the Vocational and Adult Education School at Manitowoc. The course includes discussions of the physiology of pregnancy and delivery, the hygiene of the expectant mother, preparation for the baby, and care and guidance after birth. The classes are held under the guidance of a registered nurse, fully prepared in this field.

Physicians Speak on Medical Care

"Medical Care for the American People," was the subject of a discussion presented to the Woman's Club of Sheboygan by *Drs. Eben J. Carey* of Milwaukee and *Otho A. Fiedler* of Sheboygan, at a meeting held Tuesday afternoon, February 19.

Doctor Hathaway Heads Hospital Staff

Dr. George J. Hathaway was elected chief of staff at St. Mary's Hospital, Superior, for 1946 at the annual meeting held Monday, January 28. He succeeds *Dr. T. J. Doyle*. Other elections were: *Drs. J. C. Kyllo*, vice-president; *H. B. Christianson*, secretary; and *H. J. Orchard*, chairman, *J. W. McGill*, secretary, *C. W. Giesen*, *H. A. Sincock*, and *Hathaway*, members of the executive committee.

Departmental chiefs named were: *Drs. V. E. Ekblad*, surgery; *Orchard*, medical; *D. R. Searle*, x-ray; *R. P. Fruehauf*, laboratory, *Sincock*, pediatrics; *J. H. Weisberg*, emergency, *McGill*, obstetrics, *Milton Finn*, records; *Conrad Giesen*, records; *Doyle*, ear, eye, nose, and throat; and *L. W. Beebe*, anesthesia.

Doctor Cary is Legion Choice

Dr. E. C. Cary of Reedsville has been appointed department vice-commander of the American Legion, succeeding George Ostrander of Princeton who resigned. The appointment was made by the executive committee at the midwinter conference of the Legion held in Milwaukee in January.

Doctor Buckner Named County Home Physician

Dr. H. M. Buckner of Dodgeville has been appointed physician for the Iowa County home and asylum. He succeeds Dr. C. L. White of Mineral Point who resigned.

Doctors Attend Councilor District Meeting

Drs. H. H. Christensen, R. H. Juers, Joseph F. Smith, and O. R. Kelly, the latter a pathologist at St. Mary's Hospital, all of Wausau, attended the mid-winter meeting of the Ninth Councilor District Medical Society at Wisconsin Rapids on January 31.

Veterans Named to Hospital Staff

The staff of St. Joseph's Hospital, Marshfield, honored its doctors recently returned from the armed forces by electing them to head the staff for the year. Those named were: *Drs. R. S. Baldwin*, president; *A. L. Millard*, vice-president; and *Charles Vedder*, secretary.

Doctor Ludden Leaves Viroqua

Dr. R. H. Ludden, practicing physician in Viroqua since 1928, is moving to Madison where he will open an office. Doctor Ludden recently returned from the Army Medical Corps, with which he served as a surgeon in the Pacific Theater.

Doctor Meyer to Take Florida Post

Dr. Marshall W. Meyer, district health officer for the State Board of Health, will leave Green Bay in March to join the Florida State Board of Health as administrator of the southeastern district. Doctor Meyer moved to Green Bay in March, 1943, succeeding *Dr. Allen A. Filek*. A graduate of Rush Medical College, he practiced in Chicago for three years and in Almond for nine years before becoming affiliated with the board in 1939. He was director of the State Board of Health's sanitary District No. 9 at Ashland before coming to Green Bay as director of District No. 6.

Ophthalmologist Opens Offices in Eau Claire

Dr. Lester B. Hansen, ophthalmologist, opened offices in Eau Claire early in February. Doctor Hansen has just returned from New York City where he spent six months studying at the New York Eye and Ear Infirmary, and a year and a half as resident in ophthalmology at the New York Postgraduate Medical School and Hospital.

Doctor Hansen practiced several years in Mondovi before studying in New York.

Rheumatic Fever Dangers Described

Dr. John M. MacLaren, Appleton, was the guest speaker at the Kaukauna Rotary Club's dinner meeting Wednesday noon, January 23. *Dr. George L. Boyd* had charge of the program. Doctor MacLaren's subject was "Rheumatic Fever and Rheumatic Heart." He has been chairman of the state Crippled Children's Committee for nine years.

Flying Doctor Dorchester

Dr. Dan E. Dorchester, Sturgeon Bay, maintains two airplanes which he pilots himself on calls to scattered clusters of fishermen's families on Washington Island, off the tip of the Door County peninsula. Doctor Dorchester previously sailed to the

SHOREWOOD

HOSPITAL • SANITARIUM

2316 E. Edgewood Avenue MILWAUKEE, WISCONSIN Phone: EDgewood 0900

For Nervous Disorders

A fifty bed hospital and sanitarium. Separate buildings for neurotic and psychotic cases.

Illustrated booklet sent on request.

WM. H. STUDLEY, M.D.
Medical Director
JACK L. KINSEY, M.D.
HERBERT W. POWERS, M.D.

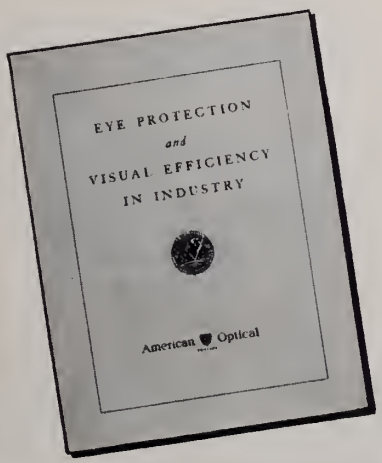
ESTABLISHED 1898

INDUSTRIAL SAFETY & VISUAL EFFICIENCY

On January 1, 1946, American Optical published a printed policy establishing the basis on which the company supplies protective goggles, corrective-protective materials, and screening devices for industrial application.

This printed policy is part of a program developed by American Optical to facilitate co-operative relations between the Ophthalmic Professions and Industry. Copies of this statement incorporating the company's policy have been mailed to Ophthalmologists, Optometrists. and Ophthalmic Dispensers.

In brief, the AO Program for Industrial Safety and Visual Efficiency:



Establishes the concept that the true benefits in industrial eye care are derived from the application of professional and technical eye care services.

Offers a workable plan by which the Professions and Industry can provide a greater measure of visual efficiency and safety to industrial employees.

Presents helpful literature and personal counsel to the Professions as they assume their responsibilities in the interest of better industrial vision.

This AO policy statement deserves the close attention of every interested professional man.

American Optical
COMPANY

island in the summer and drove over ice-covered Lake Michigan in the winter—a time-consuming, uncertain, and often hazardous trip.

Doctor Kief Tells of Army Mental Training

Dr. H. J. Kief, recently returned from the Army Medical Corps, discussed the mental hygiene training given men in the Army at a meeting of the Fond du Lac Lions Club held Wednesday, January 30. Movies were used to help show the men that the mind controls the body, said the doctor. Doctor Kief urged the incorporation of instruction periods in mental hygiene in high school educational programs, particularly during senior years.

Ophthalmologist Clinics

The third semi-annual course for Ophthalmologists' Office Assistants was given in the Pember–Nuzum Clinic Library February 2–15 by Austin Belgard, lens analyst, Chicago; *Dr. A. H. Pember*, Janesville; Dr. Ralph H. Woods, La Salle, Illinois; and *Dr. S. G. Higgins*, Milwaukee.

The Woods–Pember Clinic in Refraction and Physiological Optics will be given in Janesville October 6–11, the week prior to the meeting of the American Academy of Ophthalmology in Chicago.

Chest Disease Postgraduate Course

A postgraduate course in diseases of the chest will be given under the auspices of the Illinois Chapter of the American College of Chest Physicians at Michael Reese Hospital, Chicago, April 1–6, inclusive.

Doctors may elect to follow this week's formal course with practical instruction in the fields of thoracic surgery, bronchoscopy, pneumothorax, bronchography, and other methods and technics in the diagnosis and treatment of pulmonary disease.

Further information may be secured at the office of the American College of Chest Physicians, 500 North Dearborn Street, Chicago 10, Illinois.

Industrial Health Conference

An Industrial Health Conference, to be held at the Sherman Hotel, Chicago, April 8–13, has been announced by the American Association of Industrial Physicians and Surgeons.

This conference, which is sponsored jointly by the Association, the American Industrial Hygienists Association, the Association of Governmental Industrial Hygienists, the American Association of Industrial Dentists, and the American Association of Industrial Nurses, will be the outstanding conference of this type ever held. The Scientific Program is somewhat competitive, in that award placques for first, second, and third prizes will be awarded.

Members of the State Society who are interested in participating in the presentation of exhibits should communicate with Dr. H. Glenn Gardiner, at the office of the Managing Director, 28 East Jackson Boulevard, Chicago 4, Illinois.

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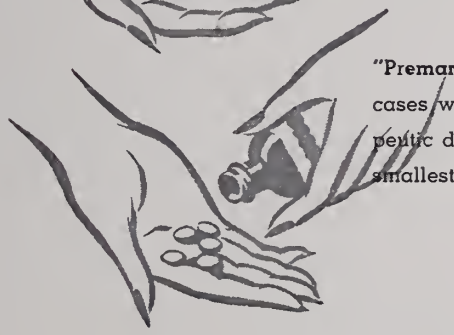

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Society Proceedings

Brown—Kewaunee—Door

The Brown–Kewaunee–Door County Medical Society met Thursday, February 14, at the Beaumont Hotel, Green Bay. A testimonial dinner for all members in service during the war is planned for March 14 at the Yacht Club.

Dodge

At their January 24 meeting, held at the Hotel Rogers in Beaver Dam, the Dodge County Medical Society heard *Dr. Harold E. Marsh* of the Jackson Clinic in Madison discuss "Medical Management of Cardiac Arrhythmias."

Meeting at the Lutheran Deaconess Hospital on February 21, the society heard *Dr. Luther E. Holmgren* of the Jackson Clinic in Madison talk on "The Diagnosis and Treatment of Varicose Veins" with motion picture illustrations. Special emphasis was placed on the newer forms of therapy.

Douglas

Meeting at the Superior Hotel on Wednesday, February 6, the Douglas County Medical Society heard *Dr. Herbert B. Christianson* discuss "Malaria: Treatment of the Acute Attack." Brandon Crawford, attorney, discussed the history and activities of the Federal Bureau of Investigation.

A public health program for the city of Superior and Douglas County was discussed.

The following officers were elected: *Drs. Milton Finn*, president; and *Herbert B. Christianson*, secretary.

Eau Claire—Dunn—Pepin

The Eau Claire–Dunn–Pepin County Medical Society met on Monday, January 28, at the Elks Club. Dr. Ray Shannon of St. Paul discussed "Problems in Pediatrics."

Fond du Lac

A meeting of the Fond du Lac County Medical Society, held at the Hotel Retlaw on Thursday, January 24, was addressed by Dr. Walter Kvale of the Mayo Clinic, who gave an instructive lecture on Anti-Coagulants, chiefly that of Dicumerol.

Green Lake—Waushara

The following are newly elected officers of the Green Lake–Waushara County Medical Society: *Drs. A. A. Beck*, Wautoma, president; *A. J. Wiesender*, Berlin, vice-president; and *H. C. Koch*, Berlin, secretary-treasurer.

La Crosse

The La Crosse County Medical Society held a meeting at the Stoddard Hotel on Tuesday, February 12. The speaker of the evening was Dr. Theodore Fritsche of New Ulm, Minnesota; his subject was "Common Diseases of the Eye."

Langlade

The officers elected for 1946 for the Langlade County Medical Society are: *Drs. E. G. Bloor*, president; *D. W. Dailey*, secretary; *W. P. Curran*, delegate; and *C. E. Zellmer*, alternate. All the doctors are from Antigo except Doctor Dailey, who is from Elcho.

Milwaukee

Dr. William W. Scott, assistant professor of surgery at the University of Chicago Medical School, addressed the Medical Society of Milwaukee County at its meeting held in the Athletic Club on Friday, February 8. *Dr. James C. Sargent*, recently returned from the Navy, spoke on Urology.

Outagamie

Meeting at the Conway Hotel in Appleton on Thursday, January 17, the Outagamie County Medical Society heard *Dr. Ralph M. Waters* of Madison speak on "Anesthesia in Small Cities, Towns, and Hospitals."

At the meeting held on Thursday, February 21, the society was addressed by *Dr. James R. Regan*, Milwaukee orthopedist, speaking on "Healing After Injury to Small Bones."

Racine

The Racine County Medical Society met at the Country Club on Thursday, January 24. Dr. Donald Cook of Zurich, Illinois, was the speaker. His subject was "The Discovery of the Primary Cause of Gastric and Duodenal Ulcers; Medical and Surgical Treatment."

Waukesha

At a regular meeting of the Waukesha County Medical Society, held on Wednesday, December 12, the following officers were elected for the year 1946: *Drs. J. P. Kelly*, Pewaukee, president; *C. A. Wood*, Waukesha, vice-president; *F. L. Grover*, Hartland, secretary-treasurer; *H. T. Barnes*, *Delafield*, delegate; and *E. C. Van Valin*, Sussex, alternate.

Wood

A combined meeting of the Wood and Clark County Medical Societies was held on Thursday, February 7, at Marshfield. The Wood County Society elected the following officers for 1946: *Drs. L. J. Bennett*, Wisconsin Rapids, president; *Hart Beyer*, Pittsville, vice-president; *R. W. Mason*, secretary-treasurer; *K. H. Doege*, delegate; and *F. X. Pomainville*, alternate delegate.

(Continued on page 346)

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(Continued from page 344)

The following scientific program was presented: "True Infective Abacterial Pyuria," *Dr. E. J. McGinn;* "Treatment of Malaria in Returning Servicemen," *Dr. R. S. Baldwin;* "Treatment of Allergic Conditions with Anti-Histaminic Substances (Benadryl and Pyribenzamine)," *Dr. S. E. Epstein;* and "Care of the Premature Infant," *Dr. A. L. Millard.* All the speakers are from Marshfield.

Dr. H. H. Christofferson, Councillor of the Ninth District, gave a short talk on "The Wisconsin Plan."

Winnebago

At their February 7 meeting, held at the Athearn Hotel in Oshkosh, the Winnebago County Medical Society heard *Dr. Robert F. Purtell* of Milwaukee discuss the Blue Cross and the Milwaukee County Surgical Plan.

Milwaukee Academy of Medicine

Meeting at the University Club on Tuesday, February 19, the Milwaukee Academy of Medicine was addressed by *Dr. Philip H. Seefeld* who discussed "The Goitrogens," presenting an abstract of the paper that won first prize in the Horace Manchester Brown Memorial Essay Contest. Dr. George E. Fahr, professor of medicine at the University of Minnesota Medical School, spoke on "Modern Digitalis Therapy."

Kenosha County Mental Hygiene Society

Holding their tenth annual meeting on Wednesday, January 16, the Kenosha County Mental Hygiene Society conducted their annual election of officers and held their annual banquet.

Dr. Margaret V. Pirsch was reelected president of the society; *Dr. A. F. Rufflo* was among those reelected to the board of directors. *Dr. Harold T. Schroeder,* director of the local guidance clinic, was the principal speaker; he presented a general discussion of the aims and purposes of the society and outlined trends in psychiatric reconstruction for individuals.

Milwaukee Oto-Ophthalmic Society

The Milwaukee Oto-Ophthalmic Society met on Tuesday, February 26, at the Athletic Club. The following scientific program was presented: "Ocular Leprosy," with colored slides, *Dr. George A. Dunker;* "The Stability of Penicillin in Ophthalmic Solutions," *Dr. E. E. Grossman;* "Problems of Facial Reconstruction," *B. P. Churchill;* and "The Fundus of Scrub-Typhus," *Dr. John B. Hitz.*

AND ABOUT THE THIRD DISTRICT:

"With a marked concentration of physicians in the Third Councilor District, the *Journal* experiments by assembling all news items pertaining to activities of physicians in Dane, Rock, Green, Columbia, Sauk, Marquette and Adams Counties and presents them together. The *Journal* urges county secretaries to send personal items of interest. Such notices should reach our office by or before the fifteenth of each month before publication."

—EDITOR'S NOTE

SOCIETY PROCEEDINGS

Dane

"Man, Mice, and Malignancy" was the topic of discussion at the Dane County Medical Society meeting held on Tuesday, February 12, in the Service Memorial Institutes building. The speaker, Dr. Leonell Strong, Ph. D., Sc. D., from the department of anatomy of Yale University School of Medicine, is a leader in the field of cancer research. His talk, which was illustrated with colored slides, dealt with the various types of malignancies transferrable in experimental animals and eventually probably applicable to research in humans. According to the doctor, cancer will be controlled by genetic principle resulting from the discovery of some mechanism within the body which produces resistance to cancer in all its phases.

A joint meeting of the society and the Dane County Dental Society was held on Wednesday, February 20, in the Washington School auditorium. The speaker was Dr. Isaac Schour, professor of dental histology at the University of Illinois, who discussed "Fluorine."

Rock

The Rock County Medical Society met at Mercy Hospital, Janesville, on Tuesday, January 29, to hear *Dr. Herman C. Schumm* of Milwaukee discuss "Acute Bone Atrophy."

A resolution on the death of *Dr. E. C. Hartman* was read and approved.

Madison Association of Medical Technologists

The Madison Association of Medical Technologists met on Wednesday, February 6, at the Wisconsin General Hospital. Dr. E. A. Birge spoke on parasitic diseases.

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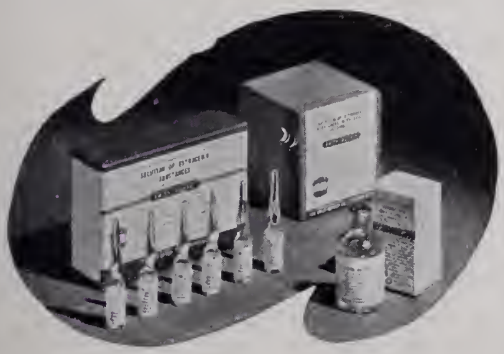

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COUNCILOR DISTRICT NEWS

Doctor Gonce to Aid in Russian Medical Relief Drive

Dr. J. E. Gonce, president of the Dane County Medical Society, has been named honorary chairman of the current drive to raise funds for medical aid to the Soviet Union. Sponsored by the Dane County Russian Relief chapter, the drive is designed to aid the Soviet Union in setting up factories to manufacture artificial limbs for Russian soldiers who suffered amputations in the war. Justice John D. Wickhem is chairman of the drive.

Emphasizing the wholesale devastation of Russia's medical facilities, Doctor Gonce pointed out that for each American who lost an arm or leg in the war, there are seventy Russian veterans suffering the same handicap.

Work of Women in Medical Corps Praised

Women of the Medical Corps were on the job for work and not for glamour, according to Lieutenant Colonel Margaret D. Craighill of the Army Medical Corps, first woman commissioned in that department. Speaking in the Service Memorial Institutes building on Thursday, February 14, Doctor Craighill listed some of the important jobs carried out by the corps women: dietitians struggled to make C rations appetizing; physical therapists did much to restore the functions of muscles and joints; occupational therapists helped restore mental functions; others helped relieve boredom by teaching everything from the technics of mechanics to radio broadcasting.

Colonel Craighill received her bachelor of arts and master of science degrees from the University of Wisconsin and her doctorate from Johns Hopkins University School of Medicine. She practiced medicine in Greenwich, Connecticut.

Doctor Nordholm Locates in Stoughton

Dr. V. W. Nordholm, practicing physician in Ellsworth for eight and one-half years, has entered into partnership with *Dr. A. T. Smedal* at Stoughton. A native of Red Wing, Minnesota, Doctor Nordholm was graduated from Northwestern University Medical School in 1937; he interned at hospitals in Minneapolis and St. Paul.

Dr. Esther Kurtz Broadcasts

Dr. Esther Caldwell Kurtz gave a radio talk entitled "Let's Talk About Your Pre-School Child" on Friday morning, February 8, on station WHA. Doctor Kurtz, a graduate of the University of Wis-

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122 So. Michigan Ave.

consin Medical School, is in charge of one of the child health centers for the care of well children sponsored by the Madison Visiting Nurse Service. The talk was the second in a series of four arranged by the service.

On Friday, February 15, *Dr. Eugenia Cameron* spoke on "The Mental Health of the Pre-School Child" on the same series. Doctor Cameron is the director of mental health in the Bureau of Maternal and Child Health of the State Board of Health. A well-known authority in this field, she has supervised the setting up of Child Guidance Clinics all over Wisconsin; there are now nine permanent clinics. Work in the clinics is done in cooperation with and referrals from local physicians, social workers, teachers, psychologists, nurses, and patients.

Doctor Evans Honored

A certificate of honorary membership in the Wisconsin Hospital Association was presented to *Dr. Joseph S. Evans*, professor emeritus of medicine at the University of Wisconsin Medical School. The award was made in Milwaukee at a meeting held on Friday, February 15.

Doctor Harris Speaks in Chicago

Dr. John W. Harris, professor of obstetrics and gynecology at the University of Wisconsin Medical School, was the guest speaker at the luncheon meeting of the Chicago Maternity Center on Thursday, February 14, at the Casino Club, Chicago.

U. W. Offers Second Medical Refresher Course

A twelve-week refresher course, designed to familiarize discharged medical officers with recent advances made in various medical fields, will be offered at the University of Wisconsin Medical School beginning March 4, according to an announcement made by *Dr. Ovid O. Meyer*, chairman of the department of medicine.

The second of its type to be offered, the course will consist of a review and study of advances made in medicine, neuropsychiatry, surgery, and allied specialties such as obstetrics, gynecology, and pediatrics.

Enrollment in the program will be limited to twenty, with all applicants over that figure referred to a third refresher course, scheduled for June.

Doctor Boner Speaks at Beth El Temple

Dr. Albert J. Boner, recently discharged from the Army Medical Corps, addressed the annual meeting of the Beth El Temple on Thursday, January 24, at the Park Hotel in Madison. His subject was "Mental Stamina In War." While in the service Doctor Boner served in the 6th Division of the 3rd Army, acting as division neuropsychiatrist.

Attends Meeting

Dr. G. J. Maloof, Madison, attended a sectional meeting of the American College of Surgeons in Minneapolis, Minnesota, on January 28 and 29.

Doctor Sevringhaus Lectures

Dr. Elmer L. Sevringhaus, professor of medicine at the University of Wisconsin, and nutrition specialist, discussed "Food for the World" at the Memorial Union Theater, Madison, on Wednesday, February 6. Doctor Sevringhaus was in Italy from April 13 to August 8, 1945, as clinical director of a special nutrition mission under the joint auspices of the UNRRA and the service committees of the Unitarian and Congregational churches.

Oldest Health Officer

Dr. Cornelius A. Harper, the nation's oldest public health officer, celebrated his 82nd birthday Wednesday, February 20—on the job. Oldest both in years and length of service, Doctor Harper's work in Wisconsin has won him national recognition. He entered public health service in February, 1901, and was named secretary and health officer in 1904.

Doctor Harper resigned as state health officer on January 9, 1943, and as acting assistant health officer January 1, 1946. He is now medical specialist in public health on the board.

Doctor Supernaw Addresses Business Club

Dr. J. S. Supernaw of Madison discussed "The Wisconsin Plan" at a meeting of the Senior Business and Industrial Club of the city Y. W. C. A. held Thursday, January 31. It was the fourth in a series of lectures entitled "Current News."

SOCIETY RECORDS

New Members

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Ben J. Axel, 904 East Johnson Street, Madison 3.

Frank M. Hilpert, 1300 University Avenue, Madison 6.

Franklin M. Dowiasch, 1300 University Avenue, Madison 6.

James E. Miller, 1300 University Avenue, Madison 6.

Dee W. Dailey, Elcho.

Henry J. Katz, 11 Center Street, Cedarburg.

Robert G. Wochos, 314 Dorelle Street, Kewaunee.

John R. Nebel, 201 Main Street, Oshkosh.

Russell F. Wilson, Beloit.

John J. Arneth, 528 North Nineteenth Street, Milwaukee 3.

Samuel W. Rosenberg, 525 East Michigan Street, Milwaukee 2.

Robert H. Pfeifer, 41 South Main Street, Clintonville.

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1. Lehr, D.: Proc. Soc. Exper. Biol. & Med. *58*:11, 1945.
2. Lehr, D.: In press.

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M. H. Wall, Superior, to Mesa, Arizona.

C. H. Feasler, Oconomowoc, to Box 752, Big Pine, California.

W. A. Adrians, Hortonville, to 301 West Seymour, Appleton.

L. M. Cox, Chicago, to MacCornack Clinic, Whitehall.

L. S. Shemanski, Menasha, to 309 South Mason Street, Appleton.

S. J. Adler, Milwaukee, to 191 South Gardner, Los Angeles 36, California.

Esther W. Goldberger, Wauwatosa, to 1830 East Kane Place, Milwaukee 2.

W. H. Schuler, Madison, to 209½ Watson, Ripon.

L. B. Hansen, Jackson Heights, New York, to 213 South Barstow Street, Eau Claire.

H. J. Kief, St. Cloud, to 104 South Main Street, Fond du Lac.

C. J. Moran, Burlington, to 548½ Chestnut Street, Urbana, Illinois.

BIRTH

A son to Dr. and Mrs. A. J. Sebesta, Shawano, on February 14.

DEATHS

Dr. Jesse R. Bryant, 78, practicing physician in Wausau since 1908, died Tuesday, February 12, at his home. He had been in failing health for more than a year.

Doctor Bryant graduated from Rush Medical College in 1896. He then practiced in Frankfort, Louisiana, and Lyndon Station, Wisconsin, for several years. After graduating from the Illinois School of Electro-Therapeutics in 1908, Doctor Bryant located in Wausau.

Before studying medicine Doctor Bryant took the pharmacy course at the University of Wisconsin, graduated in 1888, and managed a drug store in Lake Geneva for several years.

A member of the National Guard, the doctor served in Texas in 1916 as medical officer with the 3rd Wisconsin Regiment. During the first World War he served as medical officer with the 128th Infantry and the 120th Field Artillery.

Doctor Bryant was formerly a member of the Marathon County Medical Society and the State Medical Society.

He is survived by his sister.

Dr. Filip A. Forsbeck, 72, retired physician, died at his home in Oconomowoc on Friday, January 18. Born in Sweden, Doctor Forsbeck came to the United States in 1891, and entered the Hahnemann Medical College, Chicago, from which he was graduated in 1895.

After serving as a surgical interne in the Hahnemann Hospital for one year, he became associated with his uncle, the late Dr. O. W. Carlson of Milwaukee, until the latter's death in 1920.

Doctor Forsbeck was a member of the surgical staff of St. Mary's Hospital, Milwaukee, serving as its president in 1929. He was named a member of the State Board of Medical Examiners in 1897 and 1901, and served as its secretary from 1900 to 1905.

The doctor was formerly a member of the Medical Society of Milwaukee County and the State Medical Society. He was also a member of the American College of Surgeons, and the Wisconsin Homeopathic Medical Society, of which he was secretary from 1897 to 1899, and president in 1902.

Doctor Forsbeck served in the Army Medical Corps during World War I as a captain.

He is survived by his wife and one daughter.

Dr. Henry J. Goebel, a practicing physician in Racine County for thirty-seven years, died Friday, February 1, in a Racine hospital. He was 62 years old.

Doctor Goebel was graduated from the Marquette University School of Medicine in 1909, and practiced in the rural districts of the county for fifteen years, and in Racine for the last twenty-two years.

Doctor Goebel was formerly a member of the Racine County Medical Society and the State Medical Society.

Survivors include his wife and one son.

Dr. Frank O. Hunt, 78, physician and surgeon in Fall River for many years, died Friday, February 8, at a Portage hospital. He had been ill for two weeks.

Doctor Hunt graduated from the Bennett Medical School, Chicago, in 1890, and practiced in Elkhorn for one year before moving to Fall River.

In 1937, on his seventieth birthday, the community joined in a celebration, attended by many of his patients and "babies."

The doctor was a member of the Columbia–Marquette–Adams County Medical Society, and the State Medical Society.

Surviving are one daughter and one son.

Dr. Albert H. Kulig died at his home in Thorp on Sunday, January 27. He was 59 years old.

A 1910 graduate of the Marquette University Medical School, Doctor Kulig had practiced in Thorp for eighteen years. He had previously been located in Turtle Lake and Independence.

During the first World War the doctor served as a captain in the Medical Corps, both in this country and overseas.

The doctor was a member of the Clark County Medical Society and the State Medical Society; he was formerly a member of the Trempealeau–Jackson–Buffalo and the Barron–Washburn–Sawyer–Burnett County Medical Societies. He had served as the village health officer.

He is survived by his wife and three daughters.

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Dr. Felix E. Moraux died in a Green Bay hospital Tuesday, January 29, at the age of 70.

Doctor Moraux practiced medicine in Luxemburg from 1898 until his retirement in 1930, at which time he moved to Green Bay. He was graduated from the Milwaukee Medical College in 1898.

The doctor was a former member of the Brown–Kewaunee–Door County Medical Society and the State Medical Society.

He is survived by his wife, one daughter, and one son.

Dr. Bernard Schlossman, 53, Milwaukee specialist in obstetrics and gynecology, died at a local hospital Sunday, January 27, following an illness of one week.

Graduated from Rush Medical College in 1917, Doctor Schlossman practiced in Washburn for several years before moving to Milwaukee. Located in Milwaukee for the past twenty years, the doctor was a member of the staff of Mt. Sinai Hospital for many years.

He was a member of the Medical Society of Milwaukee County and the State Medical Society; he was a former member of the Ashland–Bayfield–Iron County Medical Society. He also held a fellowship in the American Medical Association.

Survivors include his wife and two sons.

Dr. Robert Sponner, gynecologist in Milwaukee for fifteen years, died Sunday, January 27, in a hospital in Tucson, Arizona. He was 66 years of age. Doctor Sponner had been hospitalized for the last two years.

Doctor Sponner, a native Austrian, was graduated from the University of Wien in 1904. He served as chief surgeon at a hospital in Stry, in the Ukraine, Russia, after the first World War.

After coming to the United States Doctor Sponner practiced for a short time in Altoona, Iowa. He studied for a few months at the Mayo Clinic, and then located in Milwaukee in 1929.

The doctor was a member of the Medical Society of Milwaukee County and the State Medical Society of Wisconsin.

Surviving are his wife and two daughters.

Dr. George B. Swenson, 67, Baldwin physician, died at a Madison hospital on Wednesday, January 30.

Doctor Swenson was graduated from the University of Minnesota Medical School in 1900. He was a member of the Pierce–St. Croix County Medical Society.

He is survived by his wife and one child.

Dr. William M. Trowbridge, 78, practicing physician in Viroqua for fifty years, died on Wednesday, January 23, at a hospital in Rochester.

Doctor Trowbridge graduated from the Hahnemann Medical School, Chicago, in 1892, and served his internship at Cook County Hospital. He also received a degree from the Chicago Eye, Ear, Nose, and Throat College in 1899, and specialized in that work.

Doctor Trowbridge was a member of the Vernon County Medical Society and the State Medical Society.

Survivors include his wife and one son.

Dr. Gustave Windesheim, 91, former Kenosha city health officer, one-time president of the State Board of Health, and a veteran of more than fifty years' service in medicine and the field of public health, died at a local hospital Saturday, January 19. He had been in retirement since 1938, and had suffered from a long illness.

Born and educated in Alsace Lorraine, Doctor Windesheim came to the United States at the age of 18. He entered the Northwestern University Medical School after he was 30, and was graduated in 1891. He practiced medicine in Chicago for several years before moving to Kenosha.

In 1912 the doctor became chairman of the Kenosha board of health. In 1918 he was appointed city health commissioner and served in that capacity until his retirement. He was a member of the State Board of Health for seventeen years, and served as its president from 1928 to 1934. A founder of the Wisconsin Anti-tuberculosis Association, he served on its board of trustees for many years.

Doctor Windesheim was in charge of Willowbrook Sanitarium for about twenty-five years, having been active in its founding. He also helped found the Kenosha Hospital, the Isolation Hospital, and the free, venereal disease, and tuberculosis clinics.

A member of the Kenosha County Medical Society and the State Medical Society, he served as president of the latter in 1918; he was elected to life membership in the State Society in 1940. He served on the Council for twenty-four years.

Mrs. Windesheim and two sons survive.

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The chairman of the Council, Dr. S. E. Gavin, has announced the following Council committee appointments for 1946.

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We urge each county auxiliary to organize a program to be featured some time in the spring to show through exhibits and speakers the great strides American medicine has taken, and to do all that it can to improve the general health conditions in its own community. We urge each member to keep herself informed on state and national medical legislation, and to write her opinions to her Congressmen in regard to such legislation.

"Physical fitness is that state of efficiency which assures maximum strength, resistance to disease, with minimum fatigue from a day's work, the glow of health and the reserve power to follow up one's avocation, as well as one's vocation." Let us strive for this goal!

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As the peoples of the world enter upon a new era it is the duty of each group to examine not so much its new privileges as its new responsibilities.

Organizations are known by their publications and so it will be the first duty of the department of press and publicity to present the Woman's Auxiliary always in the best possible light and to make all who read this section realize that this organization is aware of its responsibilities and is shouldering them. Further, this department will take every opportunity to dispel the notion which exists—alas!—even among our own members and among our husbands, that the Auxiliary meeting can be only a place where the little woman wears her new gown, sips tea, and exchanges social chit-chat.

By thoughtful presentation of the news we seek to urge members on to bigger and better projects in the work of the Auxiliary and to inspire eligible non-members to join us in what can be a worthwhile program. Finally, to make each member a press agent for our organization, we would like to see a distinctive pin adopted. It would be beautiful and unusual enough that the national organization would wish to follow Wisconsin in its adoption as the official pin for doctor's wives.

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*Davis, C. H.: Gonorrheal Arthritis Complicating Pregnancy Treated with Penicillin, Am. J. Obst. & Gynec. 50:215 (Aug.) 1945.

Hudson, G. S., and Rucker, M. P.: Gas Bacillus Infection of the Uterus Treated with Penicillin, Am. J. Obst. and Gynec. 50:452 (Oct.) 1945.

Woltz, J. H. E., and Zintel, H. A.: The Transmission of Penicillin to Amniotic Fluid and Fetal Blood in the Human, Am. J. Obst. & Gynec. 50:338 (Sept.) 1945.

Mitchell, R. McN., and Kaminester, S.: Penicillin; Case Report of a Patient Who Recovered from Puerperal Sepsis Hemolytic Streptococcic Septicemia, Am. J. Surg. 63:136 (Jan.) 1944.

White, R. A.: Puerperal Sepsis Treated with Penicillin, Southern M. J. 37:524 (Sept.) 1944.

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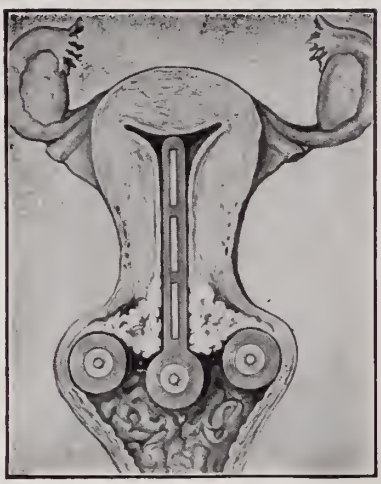

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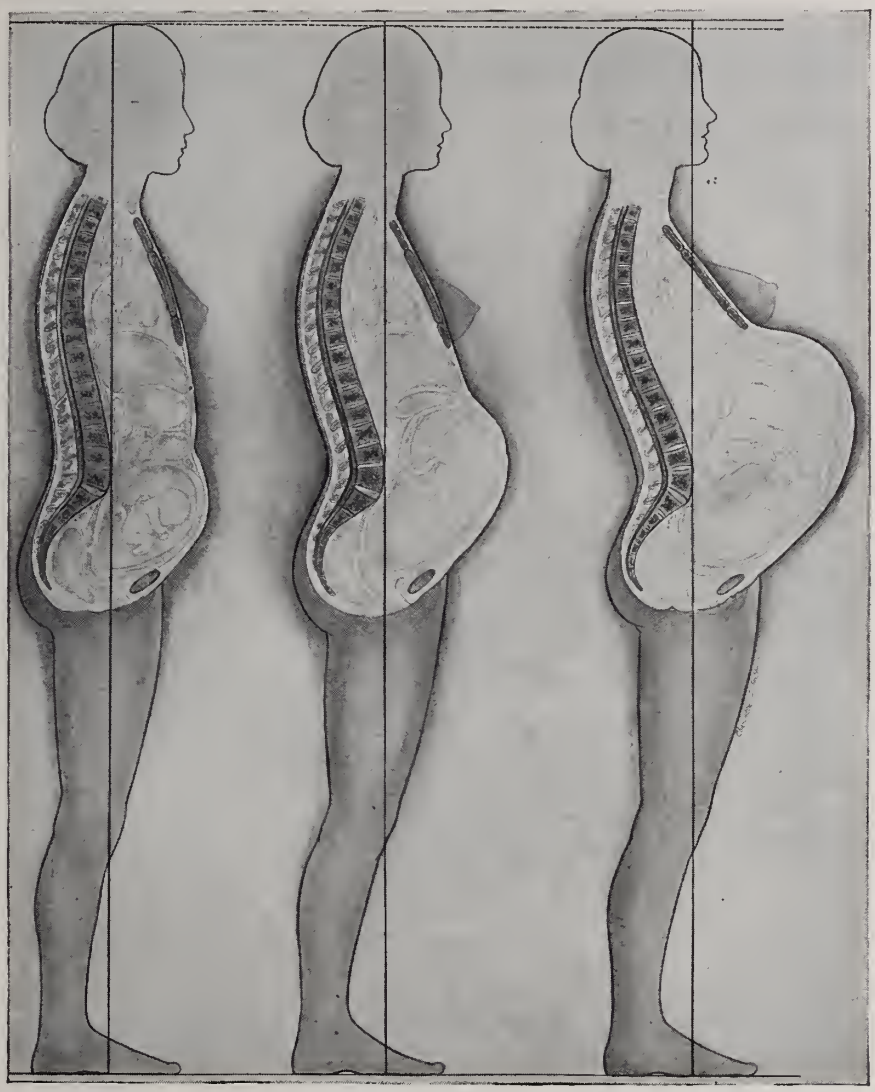

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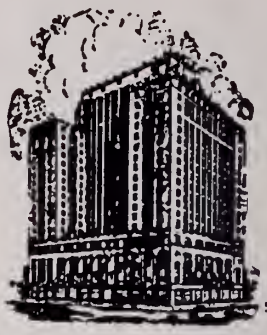

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NEWER CONTRIBUTIONS TO THE SURGERY OF INGUINAL HERNIA
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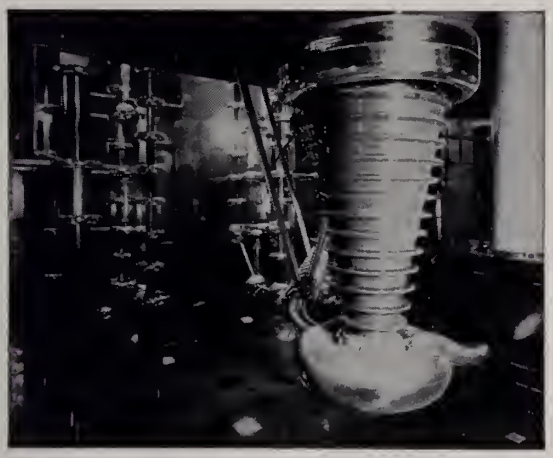

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*Wright, H. E.: Tri-State Medical Journal, July 1939

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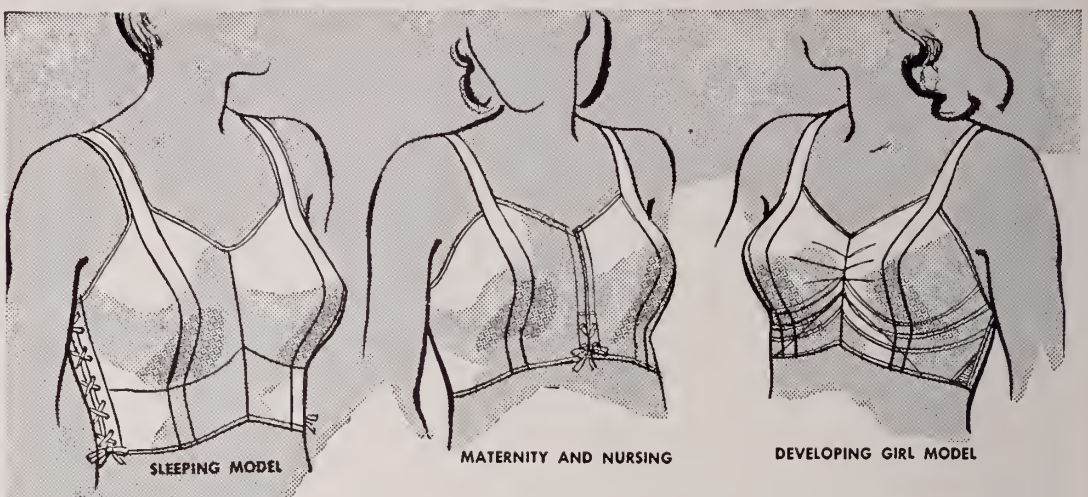

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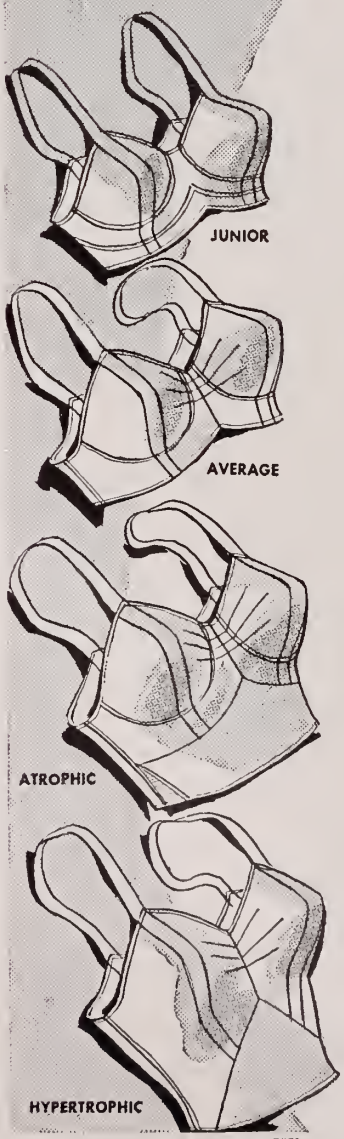

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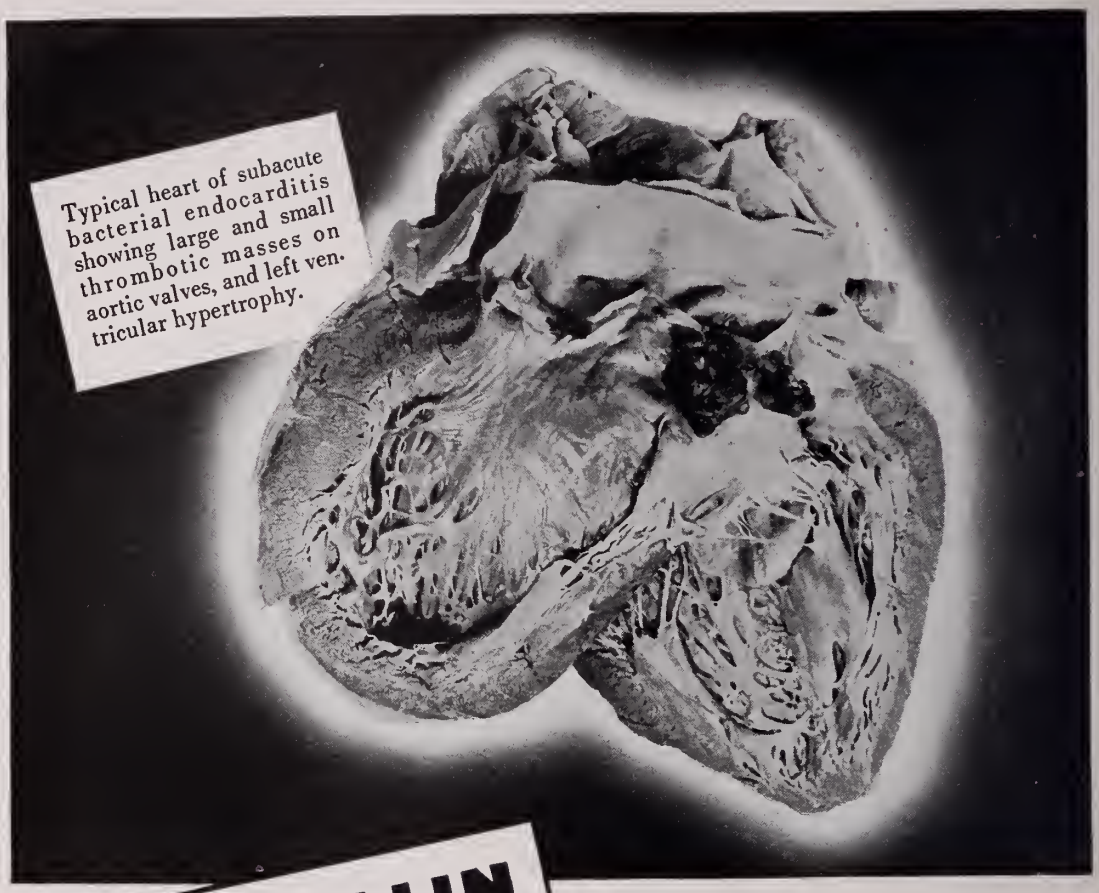

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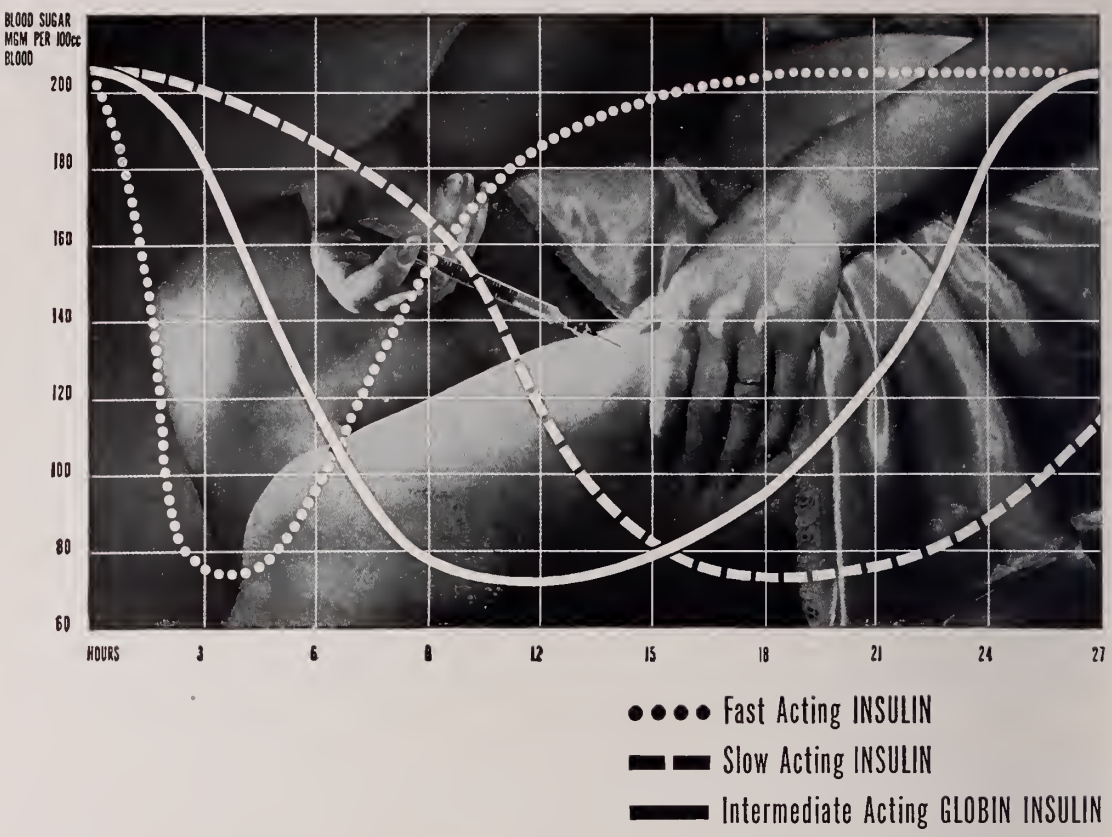

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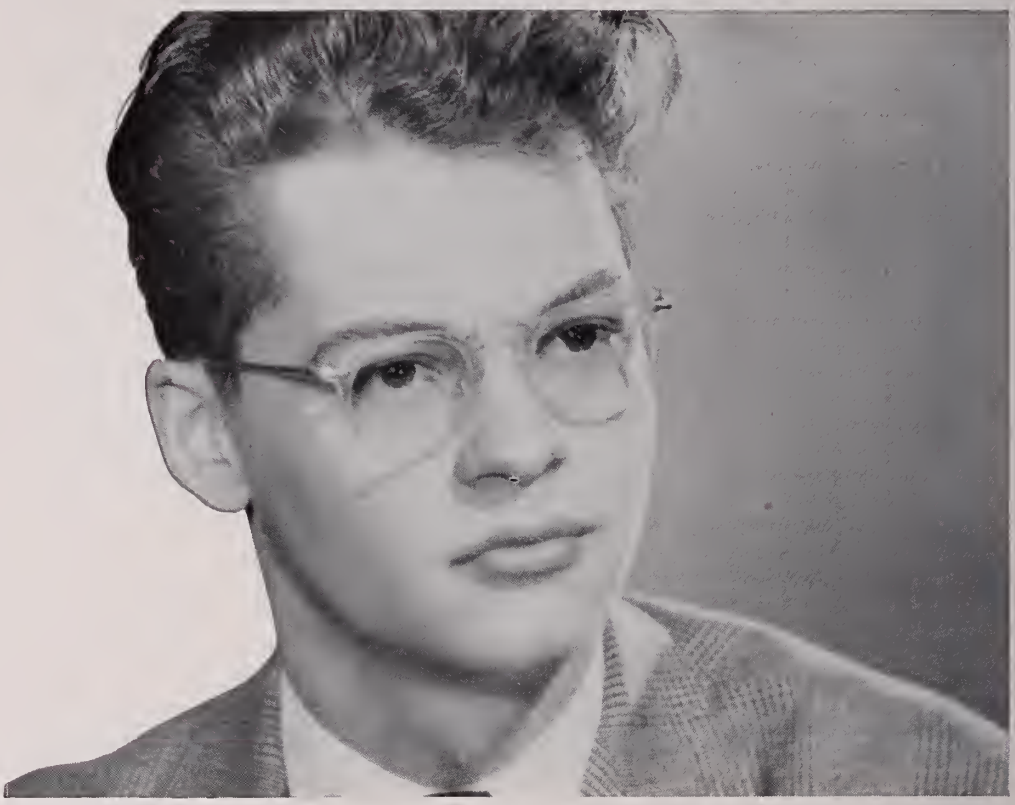

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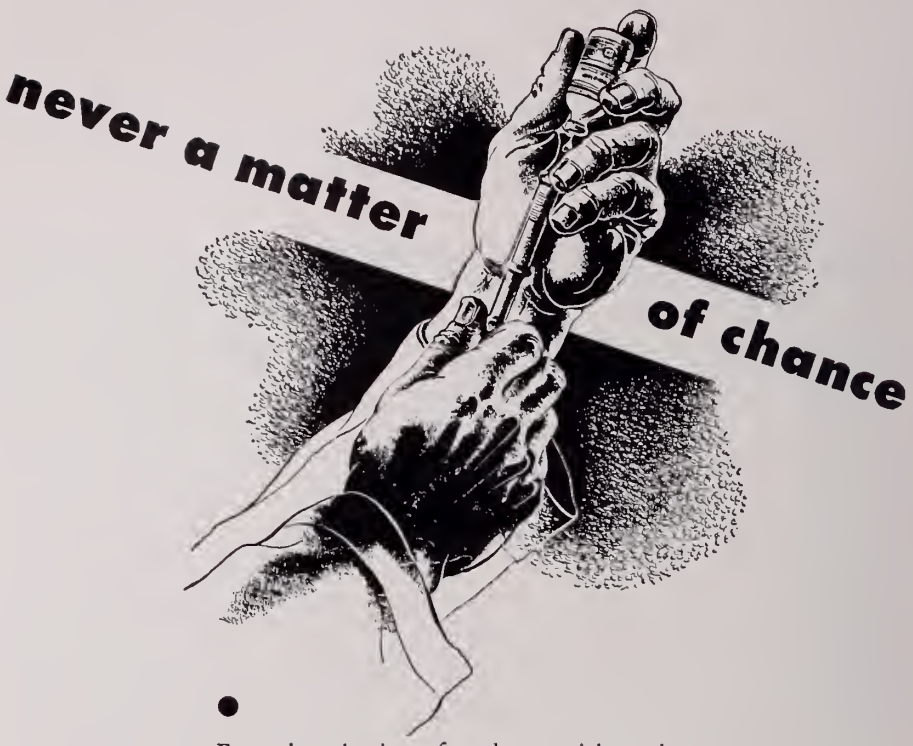

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THE WISCONSIN MEDICAL JOURNAL

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Treatment of Schizophrenia With Intensive Electric Convulsive Therapy*

Report of Case

By JAMES S. L. JACOBS, M. D., and WARREN E. GILSON, M. D.
Madison

J. S. L. JACOBS

Doctor Jacobs received his medical degree from the Columbia University College of Physicians and Surgeons, New York, in 1941.

He is an instructor in the department of neuropsychiatry at the University of Wisconsin Medical School, Madison.

ELECTRIC convulsive therapy is a valuable adjunct in the therapy of schizophrenia in spite of the fact that the results obtained do not compare favorably, in unselected cases, with those which follow courses of insulin shock treatment. The present case report describes the clinical use (by J. S. L. J.) of a modified and intensive form of electric convulsive therapy where the prognosis was unfavorable and in a situation in which insulin treatment was not available. The results obtained with this patient are of interest from the therapeutic point of view and have provided a stimulus for further investigation with this form of treatment.

Report of Case

Miss P. L. was a fifteen year old girl who complained that she had been "bothered with fears for many years." The patient's mother, a tense, oversolicitous woman of average intelligence provided the objective history. The child had presented a problem since infancy. While unusually intelligent, she had always been easily upset and it was necessary on numerous occasions to withdraw her from school because of "nervousness," although her scholastic record was otherwise excellent. She had always been overly-sensitive, shy, afraid of crowds, hypochondriacal, lacking in self-confidence, unusually self-critical, and self-conscious. Her social adjustment was poor, she had few friends, preferring the company of her family or seclusion. The immediate "nervous" episode which preceded her first admission to the hospital (May 22, 1945) was essentially similar to previous ones, being, however, somewhat more severe. It was characterized by an obsessive fear of dying, by agitation, dizziness, pains in the chest, marked anxiety, insomnia, episodes of screaming, paresthesias in the extremities and face, confusion, inability to concentrate, and a lack of interest in her surroundings. There were numerous hypochondriacal complaints referable to almost every organ. Examination revealed a very apprehensive, anxious, asthenic, sensitive, and attractive girl of superior intelligence. She showed evidence of withdrawal from reality, was moderately confused and complained that her surroundings appeared "unreal" to her. There were no delusional or hallucinatory experiences, nor thinking disturbances of a schizophrenic type. The behavior was essentially hysterical in type with intense anxiety, hyperventilation syndrome, and marked regression. Complete physical and laboratory studies revealed no abnormalities. The patient was examined under the influence of sodium amytal and no evidence of a developed psychosis was obtained. It was believed that the condition was one of acute anxiety with hysteroid manifestations in a schizoid individual and that, although a schizophrenic psychosis was not present, the possibility of such an occurrence in the future was a serious one. Treatment consisted of psychotherapy, largely given under sodium amytal hypnosis and of hydrotherapy and occupational therapy. At the time of discharge from the hospital on June 8, 1945, a

* From the Departments of Neuropsychiatry and Medical Electronics, University of Wisconsin Medical School, Madison, Wisconsin. Aided in part by a Brittingham Research grant.

marked improvement was noted. The patient had gained eighteen pounds and was free from anxiety and hypochondriacal complaints. However, her behavior was essentially schizoid in type and it was evident that only the superficial acute symptoms had been removed. The prognosis was guarded and, in view of the fact that the environmental situation at home was unfavorable (both her mother and father were emotionally unstable and constantly quarrelling, thereby causing the child much distress), it was recommended that she live with a favorite aunt during that summer. Here, for three months, her progress was satisfactory. She made an unexpectedly good social adjustment and was free from her anxiety and hysteroid complaints. About two weeks before school was about to commence, the patient returned to her home; she had had no contact with her family throughout the summer. Almost immediately after her return, her symptoms recurred. She became moody, easily excited, vomited frequently, and within a few days was very confused, incoherent, apprehensive, and engaged in bizarre behavior. No adequate exciting cause for this behavior was obtained. A panic state associated with hallucinatory and delusional experiences then developed. By the time that the patient was readmitted to the hospital, (September 7, 1945) the clinical picture had changed to that of a very withdrawn, disorganized, and disturbed schizophrenic psychotic. She was at times depressed, usually silly, and fatuous or apathetic. Emotional resonance was poor. Formal disturbances of thinking and frequent blocking were noted. Bizarre, fantastic, and "magical" delusions and hallucinatory experiences in the visual, auditory, olfactory, and somatic fields were present. Her previously meticulous habits rapidly deteriorated, rapport was poor, and it became increasingly difficult to establish contact with her. She was neither combative nor negativistic. The syndrome was one of a hebephrenic schizophrenic psychosis in a child with a prognostically poor schizoid personality, who had always exhibited a tendency towards dissociation.

Since it was not possible to administer insulin shock treatment, it was decided that electric convulsive therapy would be given. The patient received eleven such treatments (from September 8 to September 14) and at the termination of this course, her condition had not changed significantly. The hallucinatory and delusional experiences were essentially the same as those noted at the time of admission. Rapport was poor, formal thinking disturbances were slightly less marked, but her behavior and emotional status were still typically hebephrenic. She was now usually oriented but was still without insight of any form. Memory loss, secondary to electric convulsive therapy was minimal. At this time, it was decided to administer treatments more rapidly. Some time previously, Dr. V. Gonda (Chicago) had mentioned that as many as five treatments had been given during one day, in Italy. Occasionally, we had, in other patients who were acutely disturbed, administered three or four electric convulsive treatments daily. It was proposed, in the absence of an appreciable change in this patient, since her condition after the eleventh treatment was not related to the temporary "psychosis" sometimes seen following electric convulsive therapy, and in the presence of a malignant process having the past and immediate criteria for a poor prognosis, that very intensive treatment was warranted. Twenty-two electric convulsive treatments were given on three successive days; (September 17, 18, and 19) eight, seven, and seven respectively. These were administered at approximately hourly intervals. Nutrition was maintained parenterally since after the first eight treatments the patient was too confused and disorganized to take more than small volumes of fluids orally. The patient showed no apprehension, and up to the present time, has had a complete amnesia for the treatments and, in addition, the major part of her psychosis. Her behavior was essentially vegetative for four days after the last treatment. She was completely disorganized, uncommunicative, comprehended very slowly, was incontinent during the first day, and spent most of the time lying quietly on her bed. On the evening of the fourth day, her mother visited her and there was an immediate, dramatic change in her behavior. She became spontaneous and asked questions, for the first time, about her own condition and her family. A gradual improvement was noted and at no time did schizophrenic behavior, thinking abnormalities, or experiences return. There was a profound amnesia, which lasted for about four weeks and this caused the patient some distress. She left the hospital, on October 18, 1945, one month after the last electric convulsive treatment. She has been seen at monthly intervals since then; most recently, on February 20, 1946. During this period, she has remained for the most part with her aunt; occasional visits have been made to her home, she has witnessed several unpleasant and, to her, traumatic scenes between her parents, and in addition has remained alone in Madison on two occasions, for several days, while her mother was hospitalized. She has made an excellent adjustment and is not unusually disturbed by the fact that her parents are being separated. Anxiety and hysteriform complaints are no longer present. She is spontaneous and exhibits good emotional resonance. Her behavior is no longer colored by schizoid qualities. The general improvement in integration, in weight, physical well-being and stamina, in the reduction of both intellectual and emotional rigidity are commensurate with those results which are to be associated with a satisfactory remission from a schizophrenic psychosis following a course of insulin shock therapy.

Since the above patient received intensive electric convulsive therapy, a series of additional psychotics, both schizophrenic and affective, have been given this form of treatment. At this time, neither the number of

such patients nor the interval following treatment is sufficient to warrant any conclusions. The patient presented here received electric convulsive treatment with a device producing the generally used alternating current. As was noted in the case report, a profound amnesia and confusional state immediately followed her intensive treatment and this was of fairly long duration. Recently, we have employed an electric convulsive apparatus producing pulsating unidirectional current (Freidman–Wilcox–Reiter Technic). Both of these devices (alternating or unidirectional current) were designed by one of us (W. E. G.) and will be described elsewhere. It is now apparent that intensive treatment with unidirectional current is followed by amnesia and confusion of only a few days' duration. However, a comparative and critical discussion of the results obtained with intensive electric convulsive therapy with either type of current is not yet justified, nor is it the purpose of this case presentation. This form of treatment is not without hazard and although it is apparently time-saving, it does necessitate that patients be under constant observation by physicians and nurses during the course of therapy. No comparison can, at this time, be made with other forms of shock therapy.

Newer Contributions to the Surgery of Inguinal Hernia*

By COMMANDER LEO M. ZIMMERMAN, MC, USNR
Chicago, Illinois

L. M. ZIMMERMAN

Commander Zimmerman graduated from Rush Medical College in 1923 and served as Assistant Professor of Surgery at Northwestern University Medical School, Associate in Surgery at Michael Reese Hospital, and Attending Surgeon at Chicago Memorial Hospital, before entering the Navy.

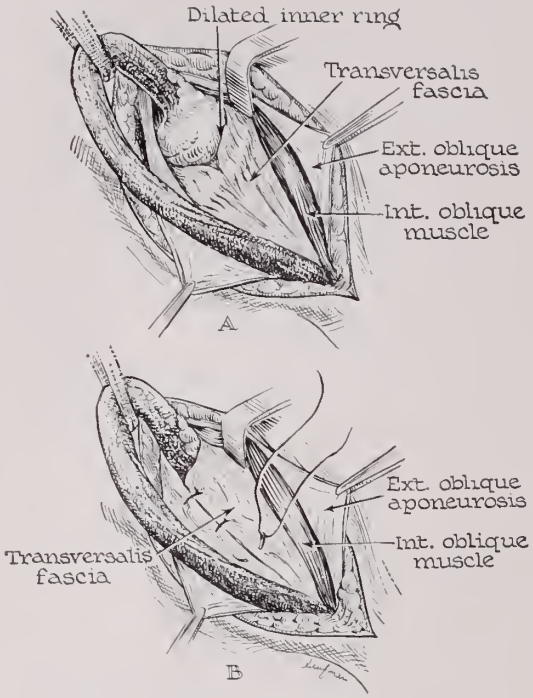
He is a Diplomate of the American Board of Surgery.

(Author's Note.—The opinions or assertions contained herein are the private ones of the writer and are not to be construed as official or reflecting the views of the Navy Department or the Naval Service at large.)

I DEEPLY appreciate the honor of being invited to appear on the program of the Annual Meeting of this Society. I was assigned the topic of Newer Contributions to the Surgery of Inguinal Hernia. I wish it were possible for me to report some new method or technic or suture material that would solve for all time this age-old problem. Unfortunately it is not so. Despite the mountainous literature that has accumulated since the advent of modern operative methods, there have been no startling or sensational innovations in the surgical treatment of hernia. The panaceas have all proved to be duds. The hopes raised by the injection treatment of hernia have collapsed like a pricked bubble. Even the use of autogenous fascial sutures has failed to live up to the high hopes originally entertained, and I believe they are being less frequently employed today than they were a few years ago.

Despite these disappointments, however, I am convinced that there has been real progress in the surgical management of inguinal hernia. The last quarter century has seen significant advances based, not on exciting new discoveries, but on sober and studious application to the prosaic fields of anatomy, physiology, and pathology of hernia; and on the refinements of surgical manipulation. Considerable thought to the problem of hernia convinces me that along these lines, definite gains have been made and that it is along these lines that future conquests are to be anticipated. At this time I should like to pay tribute to the late Dr. Edmund Andrews whose writings, in my opinion, have done more to place the subject of hernia

* Presented before the One Hundred Second Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1943.



Repair of indirect inguinal hernia, after sac has been removed.

A. Dilated internal ring with pro-peritoneal fat bulging through it.

B. Closure of the ring by suture of its medial margin to the inguinal ligament. Internal oblique muscle is retracted medially and is not included in this suture layer.

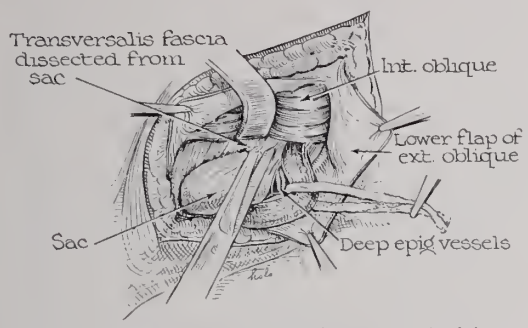
upon a firm and scientific basis than have those of any other since the days of Marcy and Bassini. I should also like to mention the anatomic studies of Anson and his colleagues in the Department of Anatomy of Northwestern University Medical School. They have made a monumental investigation of the anatomy of inguinal hernia, more complete and more thorough than any since the days of the masters, Camper, Cooper and Scarpa. I have borrowed freely from their researches in reaching my own convictions on the subject of hernia.

Assaying the recent accretions to the surgical management of inguinal hernia, certain truths must be emphasized to provide their background. First, complacence as to the results of the surgical management of hernia is not warranted. Impressions as to end results are woefully misleading. When actual follow-up studies are made, the incidence of failures is distressingly high. Second, no one method of repair, currently available, gives consistently better results than do the others. The solution to the problem is not to be sought therefore in the general adoption of any of the standard procedures. And finally, it must be emphasized that the two common types of hernia, the indirect and direct, represent two totally different lesions, based upon different congenital anatomic predispositions, producing distinct pathologic pictures and presenting, therefore, different therapeutic and prognostic problems.

There is still a too prevalent tendency for surgeons to approach the operative repair of inguinal hernia by the routine application of one or another of the accepted procedures, without a searching analysis of the anatomic defect to be corrected. Critical examination forces one to the conclusion that very often these methods are not pertinent to the problems presented. It is urged, therefore, that the two common forms of inguinal hernia be re-examined, and that operative methods be selected which logically and adequately correct the existing defects.

Stated simply, indirect hernia, by definition, is a hernia through the internal ring. The internal ring is a funnnel-shaped aperture in the transversalis fascia at the upper, outer angle of the inguinal canal, through which the cord structures leave the preperitoneal position to begin their passage through the abdominal wall. The pathology of the ordinary indirect inguinal hernia consists of but two abberations from the normal. First, there is a pre-formed sac, of congenital origin. Herniologists are in agreement that in the absence of a persistent processus vaginalis, indirect hernia does not develop, irrespective of the force or violence applied to the abdomen. When bowel or omentum enters the sac, the ring becomes secondarily dilated. This constitutes the second anatomic feature. With these two exceptions, the abdominal wall in uncomplicated indirect hernia is normal. There is otherwise no structural pattern peculiar to the patient with indirect inguinal hernia.

The therapeutic implications from this would appear clear. The pathology consists of a pre-formed sac and a secondarily dilated



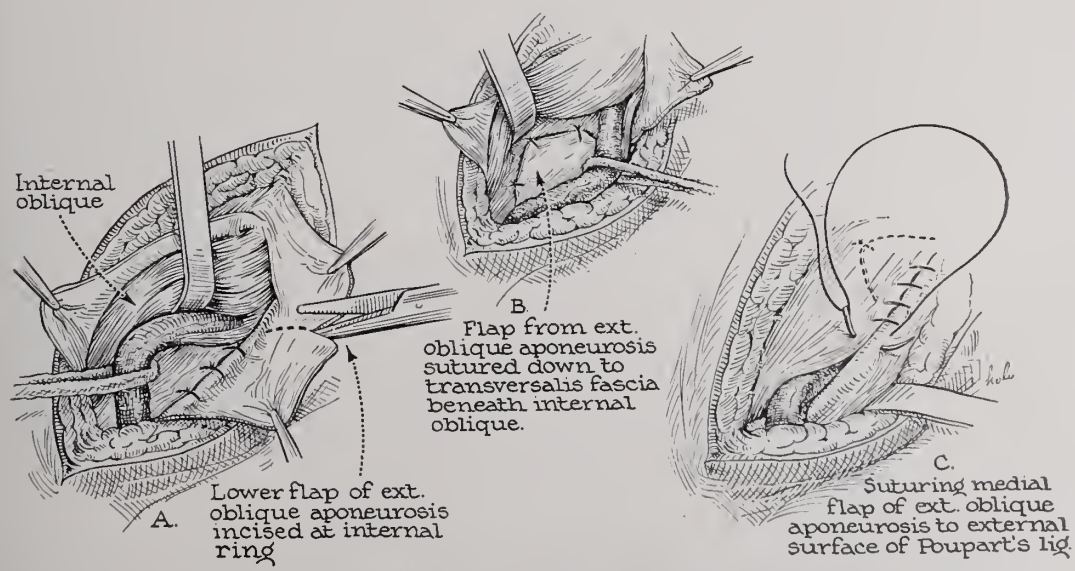
Direct hernia. Method of freeing sac by incising fibers of transversalis fascia.

internal ring. Logically, then, treatment should consist of removal of the sac and closure of the ring to its normal circumference. This is very readily accomplished by inserting one or two fine sutures in the transversalis fascia, reducing its aperture to the size of the cord. With the correction of these two departures from the normal, the inguinal canal should be just as strong as it is in persons who have never had hernia.

Most surgeons remove the sac as an essential feature of their operation. But how few ever see the internal ring, to say nothing of closing it! In none of the "standard" operations is suture of the transversalis fascia included although in his original description, Bassini divided the transversalis fascia from the level of the internal ring to the pubis, and included this structure in the "triple layer" which he brought down to the inguinal ligament, deep to the cord.

Instead of closing the ring, which is the essential lesion in indirect hernias, the routine surgical procedures attempt to strengthen the inguinal region by plicating and replicating one, two or three layers of the abdominal wall across the floor of the canal, where nothing was wrong to start with. Besides the irrelevancy of these procedures, they often are but futile gestures. The fallacy of suturing muscle to aponeurosis, and of attempting to change the course of the muscle fibers of the internal oblique, has often been pointed out. But there is a far more serious objection. Those suture methods which destroy the normal sphincteric mechanism which guards the introitus of the inguinal canal permanently impair the integrity of the wall and materially increase the likelihood of subsequent herniation.

When dealing with direct hernias, the problem is totally different. Here the essential pathology is a rupture through the posterior wall of the canal due to absence of muscular support because of a congenitally high termination of the internal oblique and transversus abdominis muscles. This presents an infinitely more difficult problem. The fallacies of the standard procedures



Repair of direct hernia. Transversus aponeurosis sutured to inguinal ligament and reinforced with flap from lateral leaf of aponeurosis of external oblique.

here are more glaringly apparent. These attempt to repair a triangular defect by suturing together two sides of the triangle, often against considerable tension. Reliance is placed upon a union of muscle with fascia, which is exposed to the strain of repeated contractions of the abdominal musculature. The inadequacy of these methods is reflected in the distressingly high incidence of failure following such operations. It is estimated that from one third to one half of all of the patients operated upon for direct hernia suffer recurrence.

There are, it seems to me, two requirements for an adequate repair of direct hernias. First, the hole in the transversalis fascia should be repaired. The importance of this is being more and more widely accepted. Second, it is necessary to sufficiently strengthen the wall to prevent subsequent herniation. Since there is no way of producing more adequate muscular support for these poorly developed abdomens, some type of fascial plastic procedure must be utilized which will sufficiently reinforce the fascial floor of the inguinal canal. In the performance of this, the dictates of an adequate plastic operation must be fulfilled. The transversalis fascia must be reinforced with a fascial layer which is brought into immediate and broad apposition with it, without tension and without interposition of any other type of tissue. There are several methods by which this may be accomplished. For a number of years, I have used a flap from the lateral leaf of the external oblique aponeurosis for this purpose with considerable satisfaction. This, or any other method which fulfills the requirements enumerated above, should prove sufficient.

As to technical considerations, it must be emphasized that no poorly conceived operation can be made good by a change in method or choice of suture material. Other things being equal, however, the utmost refinement in operative technic will be reflected in a minimum of postoperative discomfort and complications, and a maximum of successful end results. This entails the greatest gentleness in the handling of tissues, sharp dissections, precise clamping and ligation, and accurate hemostasis. My own preference is for nonabsorbable suture material. This should be as fine and smooth as possible. Short lengths of suture material and small, fine needles minimize the tissue trauma. An elastic pressure bandage gives comfort and favors healing. Early mobilization of the patient is not only safe, if a physiologic repair has been effected, but greatly curtails the postoperative disability and minimizes the incidence of vascular and respiratory complications.

Summary

Recent advances in the surgery of inguinal hernia have been in the direction of a more accurate understanding of the anatomy, a clearer conception of the pathology, and an effort to apply logical surgical procedures to the defect being repaired. Indirect hernia consists essentially of a pre-formed sac and a secondarily dilated internal ring. Logical treatment requires removal of the sac and repair of the ring. Direct hernia is a rupture of the transversalis fascia due to lack of overlying muscle support. Repair necessitates suture of the defect plus reinforcement by some type of fascial plastic procedure. The utmost refinement in surgical manipulation is demanded, and the use of fine, smooth, nonabsorbable suture material is recommended.

DISCUSSION

By IRWIN SCHULZ, M. D., Milwaukee

It is invigorating to read a paper in which the author has gone back to the fundamentals of a subject and has re-evaluated them for us. It is like meeting an old friend after many years of separation. Too often the fundamentals of treatment are forgotten by enthusiasm for this or that new procedure.

There is very little to add except to stress some of the points the author has made and apply them to our private practices. Early in his paper, he mentioned the disappointing end results of herniorrhaphy when close follow-up studies are made. When I started practicing, one of the established surgeons in Milwaukee suggested that I tell my hernia patients that I would repair them gratis if recurrence developed. This is one suggested method of follow-up for a surgeon in private practice who does not have a large clerical force available to do statistical studies for him.

Doctor Zimmerman's statement that one method of repair is as good as another might be amended by adding that in some instances one method might be more suitable than the other. Good judgment in

choosing which operation should be done can be developed only upon a sound knowledge of fundamentals.

In children, we find exemplified the author's statement that in indirect hernia, elimination of the sac is the important point of attack. In treatment of hernia in children, the sac is carefully isolated from the structure of the cord. If this is difficult, injection of salt solution through a fine needle is of assistance in separating the thin-walled sac from the cord. One should also be careful to suture the cremasteric muscle. One who has repaired hernias under local anesthesia can appreciate the importance of the cremasteric muscle by seeing it contract under increased intra-abdominal tension. The action of the cremasteric muscle plays an important part in "the sphincteric action," of which the author speaks, that guards the introitus of the inguinal canal.

It is mentioned by the author that a flap of fascia taken from the lateral leaf of the external oblique is the simplest form of support available in repair of direct hernia. Care should be taken in manipulation of fascia not to wipe off completely the attached areolar tissue. The fascia obtains its blood supply from this areolar tissue, the same as do tendons.

May I repeat the technical points that the author points out, such as gentleness; an example is the use of a penrose drain in place of gauze to hold up the cord. Sharp dissection, of course, lessens trauma. The use of tissue forceps and knife in place of sponges in freeing tissue is of value. Careful hemostasis makes operation very much easier, for in a bloodstained field it is difficult to differentiate structures and layers.

I am glad to note the author's suggestion of nonabsorbent suture; I still use silk, as long as it is available. If fascia suture is used, one that maintains its blood supply is preferable. This can be obtained by taking a small strip off the external oblique fascia, leaving one end attached. One value of the nonabsorbable suture material is that early mobilization of the patient is possible. Most hernia patients can be discharged by the seventh or eighth day after operation. The seventh or eighth day is a critical time when absorbable suture material is used; for at that time catgut is often digested.

Herniorrhaphy is not a procedure to be turned over to the intern. As far as danger to life is concerned, it is perhaps a safe procedure. However, you will all agree that it is much easier on both patient and surgeon to repair a hernia well at the first operation than to attempt a secondary repair of one that an intern had done.

One other technical point is the removal of the testicle, particularly in patients over 50 years of age who have had recurrence. This allows one to close the layers tightly. There is a smaller percentage of recurrence than where the structures of the cord must be protected.

Let us not be lulled into a feeling of self-satisfaction with our technic, because we do not see our own recurrences. Some other surgeon is seeing them.

May I stress again the importance of the operator basing his "refinements of technic" on the sound fundamental principles outlined in Doctor Zimmerman's paper.

Penicillin Therapy*

By WALLACE E. HERRELL, M. D.
Rochester, Minnesota

W. E. HERRELL

A 1933 graduate of the University of Virginia, Doctor Herrell received his M. S. in Medicine from the Mayo Foundation Graduate School in 1937, where he now serves as an Assistant Professor in Medicine.

He is a fellow of the A. M. A. and the American College of Physicians, and a member of the Central Society for Clinical Research, the American Federation for Clinical Research, and the American Therapeutic Society.

ALTHOUGH Sir Alexander Fleming[1] described penicillin in 1929 and made use of it in his laboratory, it was not until 1940 and again in 1941 that the Oxford investigators[2, 3] were able to prepare penicillin suitable for clinical use. Clinical studies on penicillin in the United States began in 1941.

One of the most remarkable properties of penicillin is its low degree of toxicity and at the same time its high degree of antibacterial activity. Penicillin also is notable because of the fact that it inhibits the growth of a variety of pathogenic bacteria, most of which are classified as gram-positive organisms. It also is effective against some gram-negative bacteria such as Neisseria intracellularis and Neisseria gonorrhoeae. Likewise, it appears to be effective against the spiro-

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chetes which cause syphilis, relapsing fever, and Weil's disease. On the other hand, there are many organisms against which penicillin is relatively ineffective. These include the colon-typhoid-dysentery organisms as well as many other gram-negative pathogens which frequently cause disease. Penicillin has little or no effect against Mycobacterium tuberculosis. It is important, therefore, for the physician to select for treatment with penicillin those infections which are due to susceptible organisms.

Susceptible Organisms

In view of present knowledge it would appear that penicillin is effective against the following organisms: Diplococcus pneumoniae, Streptococcus pyogenes, Streptococcus salivarius, micro-aerophilic streptococci, Staphylococcus aureus, Staphylococcus albus (some strains), Neisseria gonorrhoeae, Neisseria intracellularis, Actinomyces bovis, Bacillus anthracis, Bacillus subtilis, Clostridium botulinum, Clostridium tetani, Clostridium perfringens (welchii), Corynebacterium diphtheriae, Clostridium septicum, micrococci (some strains), Streptobacillus moniliformis, Borrelia novyi (spirochete of relapsing fever), Treponema pallidum, Leptospira icterohaemorrhagiae, Spirillum minus, and the viruses of psittacosis and ornithosis.

Insusceptible Organism

On the basis of the researches of the investigators who have been interested in the studies on penicillin, it would appear that the insusceptible organisms are as follows: Eberthella typhosa, Salmonella paratyphi, Salmonella enteritidis, Shigella dysenteriae, Proteus vulgaris, Pseudomonas aeruginosa (Bacillus pyocyaneus), Pseudomonas fluorescens, Serratia marcescens (Bacillus prodigiosus), Klebsiella pneumoniae, Hemophilus influenzae, Escherichia coli, Staphylococcus albus (some strains), Monilia albicans, Monilia candida, Monilia krusei, Blastomyces, Mycobacterium tuberculosis, Streptococcus faecalis, Brucella melitensis, Plasmodium vivax, Toxoplasma, and Vibrio comma.

Dosage and Methods of Administration

Opinions have differed greatly among investigators as to the proper dosage of penicillin. It would appear at present that a total daily dose of 100,000 to 200,000 units of penicillin is usually enough to accomplish cure in those infections which are owing to organisms suceptible to the action of penicillin. In general, two methods of administration are most commonly used. One is the repeated intramuscular injection of 10,000 to 20,000 units in 1 or 2 cc. of physiologic saline solution every three hours. In the beginning it was common practice to use a solution which contained 5,000 units per cubic centimeter; however, if the stock solutions of penicillin are dispensed in a concentration of 10,000 units per cubic centimeter, the inoculum is smaller and less irritation is likely to occur at the site of administration than if the concentration is 5,000 units per cubic centimeter. The sites of administration most frequently employed are the upper outer quadrants of the buttocks and the deltoid region. It is well to rotate the site of injection from one side to the other and thereby avoid repeated injections at the same site. In the administration of penicillin to infants, 5,000 units per dose is usually enough. Using the stock solution which contains 10,000 units per cubic centimeter, the inoculum is, therefore, 0.5 cc.

In the treatment of overwhelming infections, such as bacteriemia, it is well for the first few days at least to administer 100,000 to 200,000 units of penicillin by means of the intravenous drip method. The total daily dose is dissolved in 2 liters of physiologic saline solution and the rate of flow is adjusted to 20 to 25 drops per minute. When the intravenous drip method is used, the patient can be spared discomfort by using the veins on the dorsal surface of the hand and arm, which permits the hand and arm to be held in pronation rather than in supination.

When it is desirable to inject penicillin into the pleural cavity, as in the treatment of empyema, it is recommended that 50,000 units dissolved in 40 to 50 cc. of physiologic saline solution be injected daily into the pleural space. Penicillin may be introduced

also into joint cavities and into the spinal canal. The concentration most commonly used for this injection is 10,000 units dissolved in 5 or 10 cc. of physiologic saline solution. It may also be desirable at times to inject penicillin directly into the pericardial sac in amounts of 5,000 to 10,000 units dissolved in 5 or 10 cc. of physiologic saline solution.

A recent development in the administration of penicillin consists of a mixture of beeswax and peanut oil which contains 300,000 units of penicillin (calcium) in 1 cc. If this method of administration is employed, it is necessary to inject only 1 cc. of this preparation into the buttocks per day. The presence of the beeswax prolongs the action of penicillin and adequate blood levels can be maintained for twenty-four to twenty-seven hours. This method is particularly adapted to the treatment of such infections as gonorrhea, in which it may be possible to obtain cures following a single injection of this mixture of beeswax and peanut oil with penicillin.

Penicillin may be administered orally but its oral use in the treatment of severe, life-endangering infections is to be condemned. The individual variation in the absorption of penicillin following its oral administration is great. Penicillin can be used orally, however, in the treatment of mild infections which are not life-endangering. Examples of such infections are acute septic sore throats and furunculosis. In some instances, gonorrhea may be treated by this method. It should be emphasized, however, that if this method is employed one must use large amounts of penicillin. No less than 50,000 units in tablet form should be used per dose. In some instances 100,000 units per dose may be required. This amount should be given one and a half hours before meals and one and a half hours after meals. The same dose should be repeated at bedtime and once during the night if the patient is awake. At the present time oral administration is an exceedingly expensive way of treating patients and requires four to eight times as much penicillin as is required for intramuscular or intravenous treatment. It would be unfortunate if patients were allowed to obtain penicillin for oral administration without prescription and to use this material without medical supervision. I do not believe that the use of antacids is of great significance in connection with the oral administration of penicillin. It is my opinion that the main problem is a question of giving enough penicillin. It has been my practice, therefore, to use penicillin without antacids.

A word should be said about the different preparations of penicillin available. It is my belief that the calcium salt of penicillin is superior to the sodium salt. It is more stable and is easier to handle. It is the preparation of choice for the beeswax-peanut oil mixtures and also for oral administration.

Toxic Reactions

It has already been mentioned that penicillin is remarkable for its lack of toxicity. Perhaps the most common toxic reaction encountered in general practice is the toxic cutaneous manifestation. This skin reaction following the use of penicillin may come on during the time penicillin is being administered or several days after administration has been discontinued. It may take the form of urticaria (severe hives) or of an irritative form of dermatitis. On occasion swelling of the hands or feet may occur such as is commonly seen in cases of angioneurotic edema. This is not a serious reaction and can usually be controlled by discontinuing administration of penicillin. On occasion, by using a different batch or a different salt of penicillin, it may be possible to resume treatment of a patient who has exhibited this reaction. When the reaction occurs after administration of penicillin has been discontinued, the use of epinephrine may prove helpful. Occasionally dermatitis may develop from merely handling penicillin; therefore, penicillin may be responsible for what is commonly known as occupational dermatitis. If dermatitis develops while patients are receiving penicillin, administration of the drug should be discontinued, particularly if the infection is not life-endangering. To continue administration of penicillin in the face of spreading dermatitis may lead to the development of exfoliative dermatitis. This may result in a generalized desquamation.

Pain at the site of the injection of penicillin, which occurs fairly frequently, can usually be controlled by the use of one or both of two measures. Placing an ice bag at the site of the proposed injection a few minutes before the injection is made will frequently control the discomfort. Likewise, procaine hydrochloride may be added to solutions which are to be used for intramuscular injection.

Clinical Uses and Limitations

Penicillin has proved of great value in the treatment of bacteriemia. Recovery rates in cases of bacteriemia following the introduction of penicillin have been higher than ever had been experienced before. If the bacteriemia is staphylococcal, pneumococcal, streptococcal, or meningococcal, intensive penicillin therapy is definitely indicated. Likewise, patients suffering from subacute bacterial endocarditis should be afforded a trial of penicillin therapy. In this condition, it is exceedingly important to determine whether or not the organism present is sensitive to the action of penicillin. Once treatment is begun it should be continued for several weeks. It is in this condition that larger doses than were recommended earlier in this paper are probably indicated. It is recommended that 1,000,000 units per day be administered to these patients by the intravenous drip method. If the patient exhibits evidence of congestive failure, it may be necessary then to use the intermittent intramuscular method of treatment.

Among those diseases of the blood stream in which penicillin has proved of little or no value is included bacteriemia due to the common gram-negative organisms such as those belonging to the colon-typhoid-dysentery group, Proteus, Pseudomonas aeruginosa, and Klebsiella pneumoniae. Penicillin is of little or no value in the treatment of tularemia, brucellosis, mononucleosis, leukemia, malaria, or rheumatic fever.

It seems well established that penicillin is effective in the treatment of certain infections involving the central nervous system. For example, there are certain types of meningitis in which penicillin therapy is of considerable value. Meningitis of staphylococcal or streptococcal origin is not common, but intensive treatment with penicillin administered by the intramuscular or intravenous route plus daily intrathecal injections has, at times, proved lifesaving. While penicillin is of definite value in the treatment of meningococcal and pneumococcal meningitis, it is recommended that sulfonamide therapy in the form of sulfadiazine should not be discarded in the treatment of meningitis of this type. It would appear that a combination of sulfonamide and penicillin therapy is definitely indicated in the treatment of meningitis owing to Neisseria intracellularis (meningococcus) and Diplococcus pneumoniae. In the treatment of infected wounds of the brain and cerebral abscess, penicillin is of definite value when administered by the systemic route and combined with local instillations of penicillin through small tubes left in place at the time of surgical drainage.

The physician will do well to remember that penicillin is of little or no value in the treatment of such infections of the central nervous system as tuberculosis, torulosis, blastomycosis, or infections owing to Coccidioides or Sporotrichum. Likewise, penicillin is of doubtful value in the treatment of influenzal meningitis. Penicillin is also of little or no value in the treatment of poliomyelitis or encephalitis.

Certain ocular infections respond well to treatment with penicillin. Included among the conditions which have responded in a satisfactory manner to the local and systemic administration of penicillin are conjunctivitis and ophthalmitis, as well as orbital cellulitis owing to susceptible organisms. Likewise, gonorrheal as well as syphilitic ocular infections will be found to respond satisfactorily to penicillin therapy.

Certain commonly encountered infections of the respiratory tract respond well to penicillin therapy. Among the diseases involving the respiratory system which respond well to adequate penicillin therapy are sinusitis, otitis media, septic sore throat, tonsillitis, pneumonia, empyema, pulmonary abscess, and mediastinitis. It should again be emphasized, however, that these infections of the respiratory tract will respond only if the infecting organism is one which is sensitive to

the action of penicillin. Certain important infections involving the respiratory system do not respond, as a rule, to penicillin therapy. Important in the list of infections of this type which do not respond well are tuberculosis, blastomycosis, yeast and fungus infections, Friedländer's pneumonia, primary atypical pneumonia, and influenzal pneumonia. If penicillin has any place in the treatment of this group of infections it is only in connection with the treatment of secondary infection which may complicate the conditions mentioned.

It seems well established that penicillin is of value in the treatment of certain types of osteomyelitis. Acute osteomyelitis at times may respond satisfactorily to intensive treatment with penicillin. It is important, however, to remember that penicillin therapy may be associated with a so-called masking effect even more pronounced than that encountered with sulfonamide therapy. If a focus develops, it should be drained. Penicillin combined with eradication of foci has proved of value in the treatment of mastoiditis. If penicillin is to prove of value in the treatment of chronic osteomyelitis, it must be combined with adequate surgical drainage and removal of devitalized and infected bone.

There are certain important infections involving the skeletal system which do not respond to penicillin therapy. For example, rheumatoid arthritis, rheumatic fever, tuberculosis of bone, and spondylitis associated with undulant fever or typhoid fever will not respond to penicillin therapy.

There are certain important infections involving the skin and soft tissues which respond well to penicillin therapy. Exceedingly satisfactory results have been obtained following the use of penicillin in the treatment of furunculosis, carbuncle, impetigo, cellulitis, and parotitis, as well as infected wounds, ulcers, and burns. There are many infections involving the skin and soft tissues, however, in which penicillin is of little or no value. For example, penicillin is of little or no value in the treatment of chickenpox, herpes, acne, pemphigus, lupus erythematosus, blastomycosis, granuloma inguinale, myositis, or dermatomyositis.

There are some infections of the genito-urinary system which respond well to treatment with penicillin. It seems well established that uncomplicated as well as complicated gonorrhea usually responds in a satisfactory manner to penicillin therapy. Uncomplicated gonorrhea, as a rule, can be eradicated following twenty-four hours' therapy with penicillin. When complications of gonorrhea such as ophthalmitis, arthritis, and proctitis are present, it is important to continue penicillin therapy for several days. There are certain other infections of the genito-urinary system which respond well to penicillin provided the infection is due to a susceptible organism. The conditions which have responded well to penicillin include pyelonephritic abscess, pyelitis, cystitis, prostatitis, and urethritis. Likewise, epididymitis, balanitis, and pelvic cellulitis owing to susceptible organisms have been found to respond in a satisfactory manner.

There are certain frequently encountered infections of the urinary tract, on the other hand, which do not respond well to penicillin. Infections of the urinary tract due to Proteus vulgaris, Pseudomonas aeruginosa, and organisms belonging to the colon-typhoid-dysentery group will not, as a rule, respond to penicillin treatment.

It seems well established that penicillin is of value in the treatment of early syphilis as well as in the treatment of certain forms of late syphilis. Gummatous syphilis involving the soft tissues responds well to penicillin therapy. Likewise on occasions congenital syphilis will be found to respond to this form of treatment. It will require considerable time to evaluate penicillin in the treatment of syphilis. It would appear, however, at the moment that it is of doubtful value in the treatment of certain forms of late syphilis such as, for example, neurosyphilis.

There are certain miscellaneous infections in which it would appear that penicillin therapy is definitely indicated. Included in this group of conditions are actinomycosis, anthrax, rat bite fever, and Vincent's angina. I should like to mention two or three important infections in which penicillin may be of value but in which it should not be used alone. Penicillin should be employed in the

treatment of gas gangrene, tetanus, and diphtheria. On the other hand, it is extremely unwise to rely on penicillin alone in the treatment of these three important infections. While penicillin may inhibit the organisms which cause these infections, it will not have any effect on the toxins elaborated by these organisms. The physician will, therefore, do well to combine penicillin with antitoxin or antiserum in the treatment of these infections.

I hope I have emphasized the importance of penicillin therapy in the treatment of certain infections commonly encountered in general practice. On the other hand, I hope that at the same time I have pointed out its limitations. The successful use of penicillin depends entirely on the physician's ability to select for treatment those conditions which are most likely to respond to its use. Many other selective antibacterial agents are available and will become available. With these agents the physician is in a better position than he was to make a rational approach to the problems of chemotherapy and antibiotic therapy.

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APPLETON STATION NOW PRESENTS "MARCH OF MEDICINE"

On Friday, March 29, radio station WHBY in Appleton started to broadcast the weekly transcribed series, THE MARCH OF MEDICINE, sponsored by the State Medical Society. The program will be presented each Friday at 2:15 p. m.

The MARCH OF MEDICINE is now presented on thirteen stations in Wisconsin and four in Upper Michigan. Each of the stations carries the broadcasts without charge, as an educational feature, in the interests of improving the public health. The series is recommended by the Wisconsin Joint Committee for Better Radio Listening.

SCHEDULE OF THE SERIES:

Appleton	WHBY	1230 kc.	Friday	2:15	p. m.
Ashland	WATW	1400	Saturday	8:15	a. m.
Eau Claire	WEAU	790	Wednesday	4:15	p. m.
Green Bay	WTAQ	1360	Friday	3:45	p. m.
Ironwood, Mich.	WJMS	1450	Saturday	8:15	a. m.
La Crosse	WKBH	1410	Thursday	4:00	p. m.
Madison	WIBA	1310	Saturday	9:45	a. m.
Manitowoc	WOMT	1240	Saturday	4:30	p. m.
Marinette	WMAM	570	Thursday	4:00	p. m.
Marquette, Mich.	WDMJ	1340	Saturday	8:15	a. m.
Medford	WIGM	1490	Thursday	11:00	a. m.
Milwaukee	WEMP	1340	Saturday	11:30	a. m.
Rice Lake	WJMC	1240	Monday	2:45	p. m.
Stevens Point	WLBL	930	Monday	11:30	a. m.
Superior	WDSM	1230	Saturday	10:00	a. m.

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Benzyl Penicillin

The fact seems to be established that penicillin may be effectively given by mouth. Various observers have found that incorporating it in oil or in oil and beeswax, or enclosing it in double capsules with an enteric coating, or employing it together with an antacid favors its survival to some extent and makes possible the achievement of a higher blood titer. However, as time passes and more work is reported it begins to become apparent that the advantages derived from such adjuvant therapy are not as great as we earlier thought them to be, for the chief ingredient of success with any of the oral methods of administering penicillin consists in giving the agent in huge amounts —when we do this enough seems to survive to yield satisfactory therapeutic levels even though no precautions are taken to protect against the destructive action of gastric juice. But the necessity to administer four or five times as much of the drug by mouth as would be given intramuscularly imposes a heavy financial burden upon the patient even at the current reduced price of penicillin. Therefore it seems to me timely to place this short note in the *Journal* regarding benzyl penicillin, for the preliminary reports of work with this agent indicate that it may prove to be about as effective when given by mouth as the other penicillins when given parenterally.

Benzyl penicillin, developed by Tainter (1945) and his associates, is prepared by treating free penicillin in an inert organic solvent with an excess of phenyl diazomethane, extracting the unreacted penicillin with sodium bicarbonate, and evaporating the solvent down to the ultimate resinous product. The agent is soluble in sesame oil and in propylene glycol, both of which are much used solvents for pharmaceuticals, and it is said to be stable in solution at room temperature. One may therefore expect that when benzyl penicillin becomes commercially available it will be supplied to the physician ready for use. Following extensive animal experimentation, benzyl penicillin was administered to human volunteers for tolerance and toxicity studies, the amounts used being considerably in excess of those which would be employed in ordinary therapy. No gastric distress or untoward reactions were experienced by any subject, although some of the individuals did report eructation of a "benzyl acetate" odor. Physical examination of the volunteers at the end of the test period of five days at four doses per day, as well as blood and urine studies made throughout the course of the test, revealed no evidences of any type of intolerance or toxicity.

So far as I am aware the only clinical trial of benzyl penicillin that has been reported is that of Gamble, Miller, and Tainter (1945), who employed it in the attempt to check an epidemic of impetigo contagiosa in a hospital nursery. Ordinary penicillin had previously been used successfully in impetigo by several observers, who employed it in the form of an ointment or a spray after removing the crusts or else gave it intramuscularly in the usual manner. When used according to either of these methods complete healing of the lesions has usually occurred in from three to seven days. But in the series of Gamble et al., in which benzyl penicillin was employed by mouth, 8 of the 15 cases were cured in one day of treatment (6 doses) and the remaining cases with only two days of treatment (12 doses). Of course demonstration of the superiority of this new penicillin variant in a small series of cases of impetigo tells us nothing of what the drug will do in pneumococcic pneumonias or in systemic staphylococcic or streptococcic infections, but it does seem to be a straw in the wind and to indicate that benzyl penicillin may be a drug worth watching.—HARRY BECKMAN.

Notes on Clinical Pathology

Editors—WALTER H. JAESCHKE, M. D., University of Wisconsin, Madison, and
S. B. PESSIN, M. D., Marquette University, Milwaukee

Tests For Occult Blood on Stool Specimens

It would seem appropriate during April, which is also known as "Cancer Month," that some reference be made to the matter of cancer diagnosis. It should go without saying that the more aggressive we are in seeking the early cancer patient the more certain will be our good results.

One method which will aid in "screening" a large number of cases is to do occult blood tests on the stool of every patient, much as one would do a urinalysis. The technic is very simple and is accomplished by any of the standard textbook means, but for the sake of simplicity a rough screening test will be presented here.

Many times the failure to conduct this simple test is excused by saying that the patient has not been on a meat-free diet. In spite of other opinion it is safe to say that most ordinary diets, including well-cooked meat, will not give positive tests. If a patient should show a positive test and has not been on a special meat-free diet, then he can be placed on an absolutely meat-free diet for 72 hours and the screening test run more carefully. This may require a slightly more elaborate technic to be quite sure of the presence of blood. Suffice it to say that a positive test can be given by anything from a nose bleed to hemorrhoids, but any patient giving such reaction is deserving of further examination to rule out early gastro-intestinal malignancy. Pathologic examination of gastro-intestinal malignancy specimens almost invariably shows early break-down of malignant tissue with consequent bleeding into the gastro-intestinal tract. It is conceivable that this may not occur in a given case, but the likelihood of its occurrence is overwhelming.

The simplified "screening" technic is as follows: The reagents can be purchased from any standard drug supply house and ordinary 3 per cent hydrogen peroxide solution can be picked up any time in any drug store. About one gram of benzidine (special for blood tests) is added to about 5 cc. of glacial acetic aicid. This can be shaken to aid in dissolving and to the supernatant clear fluid approximately an equal amount of hydrogen peroxide solution may be added. This mixture usually has an opalescent appearance, and if it is allowed to stand in a test tube for a few minutes one may see whether the glassware itself is free of blood. If it does not turn blue it indicates the glassware is free of blood. It is often well to check a positive control with anything that has either old or fresh blood on it; for example, a piece of filter paper or cotton. A small amount of the testing solution is poured onto the bloody surface and a positive control will show as a dark blue spot wherever it contacts the blood. If it fails to show a positive control the great likelihood is that the hydrogen peroxide is too old. One may substitute gum guaiac in place of benzidine. The actual test is done by applying a few drops of the testing solution onto the surface of the feces. For convenience the feces may be spread on a glass slide. A rapidly developing blue color indicates the presence of blood.

The more refined technic, when one encounters a positive test, can assure one with greater certainty that the reacting material is blood. This consists of shaking a small amount of feces with ether to remove the fat. Then the feces is acidified with glacial acetic acid and shaken with ether again. Acid hematin is soluble in ether so that the second sample of acidified ether contains blood pigment if there is any present in the feces. This can be poured out into a clean evaporating dish and the same tests as described above can be applied to it.

One should be hesitant about making any definite statements as to the cause of blood in the stool, but by the "screening" method we can know that further work must be done.
—L. J. VAN HECKE, M. D., *Milwaukee.*

As It Looks From the Nation's Capital

Wisconsin is but one of many state, area, or specialty medical societies. Its perspective is that of a mid-western state. But its problems, at least in part, are also problems elsewhere. These pages are provided periodically for the reactions of medical leadership in other parts of the country.

THEODORE WIPRUD

Mr. Wiprud is executive secretary of the Medical Society of the District of Columbia, and a professor of medical socioeconomics at Georgetown University School of Medicine. He served as executive secretary of the Medical Society of Milwaukee County for nine years before going to Washington in 1938.

Anyone seeking tranquility will not find it in Washington. This has been especially true since V-J Day. It had been expected that with the coming of peace conditions would return to somewhat near normal, but the contrary has been true. The international situation, as is well known, has been very disturbing, taking precedence over everything else. However, domestic problems have not been ignored.

In Washington's superheated, tense atmosphere it is admittedly difficult to keep one's perspective. This applies to physicians as it does to everyone else. As a matter of fact, physicians in the Nation's Capital are very sensitive to the fluctuating currents of official thought, speech, and action. They become familiar with the views of public officials long before they are known to the country generally. Some find the opportunity of discussing the medical situation with members of Congress. They know pretty much what the Administration from the President down thinks about the doctors. In fact, they are frequently told off- and on-the-record where the medical profession stands.

As always Washington is rife with rumors. Many of them have no basis in fact, but there are others which justify investigation. Washington doctors can usually evaluate these rumors at their true worth.

On the Hill there has been a growing interest in health legislation. Bills in increasing numbers have been introduced in recent sessions and this year is certainly no exception. It can be safely prophesied that there will be no respite from health legislation so long as officials in Government bureaus charged with drawing blueprints for a national health program are in strategic positions. Administrations may come and go but these officials will go on with their tasks, keeping a steady eye on their objectives. What the final outcome will be depends to a considerable degree on which way the United States veers politically and the quality of medical leadership.

Organized medicine, particularly its leaders, is not in good graces with the present Administration. Whether this antagonism can be overcome is somewhat doubtful. One thing is certain, the multiplicity of organizations purporting to represent the best interests of the medical profession will not help this situation and is therefore a source of serious concern to the better informed Washington physicians. It has been reported that several of these organizations plan to have their representatives participate in the hearings on the Wagner–Murray–Dingell bill to be held in Washington in April. Nothing could be more short-sighted. Inevitably they will work at cross purposes even though their objectives are the same.

Despite the unenviable position of organized medicine at the present time the prognosis with respect to the Wagner–Murray–Dingell bill is not unfavorable. As seen from the District of Columbia it is doubtful that this legislation will be enacted regardless of what physicians do. With respect to the future, that is another matter.

It has become trite to say that we must provide far-sighted, realistic leadership in the health field if medicine is to remain free; nevertheless, this truism bears repetition. It is not enough to agree with it, as many physicians do, but it must be made a living thing. In this connection our greatest hope lies in younger physicians. Most of them, having been in the armed forces, are now returning to practice. Their experience has broadened their outlook and they are now more mature than they would have been had there been no war. Mention should also be made of the fact that there is a great opportunity open to medical schools to enlighten their medical students in regard to the social and economic phases of medicine. This is an obligation which has too long been ignored and it must not be neglected further if physicians are to fulfill their obligations to society.

Most physicians in Washington do not view the present situation pessimistically. They do hope for a more realistic appreciation by physicians everywhere that the present conflict will continue until an acceptable national health program has been evolved. Organized medicine has made a beginning but has a long, long way to go.—THEODORE WIPRUD, *Washington, D. C.*

As It Looks to Your State Board of Health

(These timely discussions of health problems are prepared by staff members as a special service to Wisconsin's physicians.)

Diphtheria

Diphtheria is on the rise again in Wisconsin. This, doctor, as you know, is a serious business. Diphtheria reached its lowest point of prevalence in 1941 when 47 cases and 1 death were reported. Since that time the incidence has increased. Last year the number of cases reported was 108 with 11 deaths and this year information has been received of 6 deaths in the first two months. While last year's totals are small compared with the existing status of a few years ago and may be within the bound of natural fluctuations, they may also indicate that a more severe type of diphtheria may be gaining foothold. In the United States at large the tabulations of the U. S. Public Health Service show that the number of cases has been increasing for the last two years.

Diphtheria in Europe

Diphtheria began to increase in frequency and severity in Germany before the war, becoming of very serious proportions in both the army and the civilian population during the war. Prior to the war the countries adjacent to Germany were having low diphtheria rates, but when German troops infiltrated into foreign territory diphtheria became epidemic and most of the European states were involved in consequence. Some of the cases that occurred in Germany were so severe that antitoxin had little effect. Immunization in that country has not been as successful in protecting against the disease as in this country, but according to available accounts the death rate in the immunized has been much lower than in the non-immunized. The soldiers in Europe are returning home but the time spent in return exceeds the incubation period of diphtheria and there is a chance for the culling out of active cases. Diphtheria, however, is kept alive by unknown carriers and it may be possible for the European situation to influence the prevalence and severity of diphtheria here.

Age Prevalence

Before the days of immunization a very large part of the cases and fatalities occurred in children. The records of the large cities showed that the highest number of fatalities occurred in the pre-school child. When both urban and rural sections were included the Wisconsin records for the ten years prior to the advent of immunization indicated that there were nearly as many fatalities in school children as in the pre-school child. With the progression of immuization the age prevalence of such cases as now occur has been shifted to older groups. In an analysis of 108 cases reported in Wisconsin last year, 35 were beyond 20 years of age, ranging up to 70. Of the 11 deaths recorded, 5 were in pre-school age, 2 in school age, and 4 beyond 30 years of age.

Immunization

In the ten years prior to the introduction of immunization the number of cases of diphtheria in Wisconsin averaged about 3,000, with close to 300 deaths annually. The very remarkable drop, year by year, following immunization, is testimonial to its value. In immunizing we must still be guided by the age prevalance in the pre-immunization period as indicative of where the chief danger lies. Immunization has been carried on for many years in school and other group programs and in physicians' offices. The difficulty of inducing parents to bring small children in is evident from such summaries as the public health nurses are able to collect. Outside of the city of Milwaukee, which has an outstanding record, the immunization summary for Wisconsin in 1944 is as follows: under one year of age, 5,695; 1 to 4 years, 18,899; 5 years and over, 34,856. There are between 50,000 and 60,000 children born in Wisconsin each year. The tabulation speaks for itself in indicating where greater efforts are needed in immunization.
—H. M. GUILFORD, M. D., *Director, Bureau of Communicable Diseases.*

. . . . THE PRESIDENT'S PAGE . . . .

Let There Be Less of Misleading Medical Stories

IN RECENT months there has been a considerable increase in the volume of medical articles appearing in lay journals. The style of presentation is radically different from that found in medical publications. The difference arises out of the dissimilarity of medical ethics from the ethics of the Fourth Estate. The Press has refused to believe that fact, unembellished, can constitute a story, for the story motif is the compelling incentive that makes for wide circulation and lucrative advertising. Any literary production that fails to subscribe to this first desideratum, regardless of factual excellence, can expect from the editor a most unfriendly reception. Publishers of lay journals and newspapers regard medical ethics as a survival of the primitive, something to be classed with the dodo bird. And this because the profession frowns on personal advertising and insists on giving facts without entertainment features.

Medicine has learned caution in discussing disease and remedies, for there are no cure-alls. Operation does not always cure appendicitis though it is the accepted treatment. Any medical statement that is not entirely factual may mislead the sick into raising a hope that can not be realized. Several valuable drugs have been developed in the past decade along with many of doubtful value and more of no value. These have been exploited in the journals in a spirit of enthusiastic promise. Some doctors have been induced to overcome their scientific reticence that they might pose in the limelight of publicity, hailed as great discoverers. They have forgotten that the modesty of Banting did not dim the glory of his achievement.

If the distorted figure of autocratic, compulsory, federalized medicine were stripped of its story features, its vague statistics, its melodramatic appeals and its unwarranted assurances and deflated to its undemocratic actuality, this medico-political monstrosity would soon pass to the graveyard of discarded nostrums.

Let there be less of misleading medical stories. The scientific, meticulously prepared medical paper offers the profession and public the truth, so far as is known, and is the carrier of the best of promises, the promises that can be fulfilled. Truth may be dull to many, but is, nevertheless, the essence of reasonable hope, the measure of things possible. It will project its quiet radiance down the centuries when the ephemeral flashings of error shall have faded into the limbo of nothingness.

P. R. Mirahan

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« « « EDITORIALS » » »

Introducing the Guest Editorialist

"I'M FROM Missouri" has long been a term challenging proof, and of late it has had the connotation of a growing source of national influence. In the person of the guest editorialist, *The Wisconsin Medical Journal* is pleased to present one of Wisconsin's citizens, Missouri born and educated, with graduate training in economics and law in the University of Wisconsin. Leaving a teaching position with the university, Stanley Rector in 1934 joined the Industrial Commission of the State of Wisconsin as a member of the staff of the newly formed Unemployment Compensation Department, and is now its chief counsel.

During recent years Mr. Rector has assumed added burdens, serving as the legislative chairman of the Interstate Conference of Employment Security Agencies, an association of forty-eight state unemployment compensation agencies. With his efforts in that work in opposition to the establishment of a nationalized and centralized program in the fields of unemployment compensation and employment services, Mr. Rector has been required to leave his Madison home, his wife, and two lively youngsters, Pam and Mike, to journey to the Washington scenes to appear before congressional committees, not infrequently as the personal representative of the Governor of Wisconsin.

The *Journal* presents with pleasure the thought-provoking guest editorial of Mr. Rector, expressly written for this issue.

State Action — A Vaccine Against Federal Health Programs

OPINION polls and other indices of popular thinking evidence an unmistakable public concern with what may be called the economics of illness and medical care. Correctly diagnosed, this public concern is not motivated by any changing conceptions as to the nature and form of medical practice. It marks, rather, an increasing public interest in the general idea of making some provision, through methods of prepayment, against the financial risks involved in injuries and sickness—loss of earning power and medical expense. However, the medical profession is generally apprehensive, and not without considerable justification, that certain of the presently proposed federal health programs, ostensibly featuring compulsory coverage and prepayment, would, regardless of protestations by the sponsors, work basic changes in the practice of medicine.

Intelligent leadership in organized medicine, recognizing public reaction, is attempting to design prepaid medical care programs that will not in their operation appreciably interfere with medical practice. The sponsorship by the State Medical Society of Wisconsin, in the last legislative session, of Chapter 494, Laws of 1945, and the recently announced American Medical Association program are illustrative.

It would appear, however, that this leadership plans to rely entirely on voluntary prepayment programs and to stand adamant against any and all forms of compulsory coverage and prepayment programs under the surveillance of government.

If this be the plan, its wisdom is respectfully questioned by many individuals who are likewise actively opposed to the idea of a strongly centralized and paternalistic national government. If reliance on purely voluntary programs is continued to the bitter end, and yet proves in the end to have been ill-advised, it should be clear that the proponents of a comprehensive national compulsory health program would then have the field pretty much to themselves. The way would then be closed to any better alternative, and wide open for federal action fulfilling the present fears of the medical profession.

As a vaccine against the presently proposed, all-embracing, and extensive national health programs, it is suggested that medical groups estimate the advantages that may well attach to the enactment, on a state basis, of certain types of compulsory coverage and prepayment plans. Compulsory coverage and prepayment programs, enacted and administered by the *right* kind of government, would have certain inherent advantages. Such programs, on a state basis, would strike a better balance between the interests of affected groups and be better adapted to local opinion and conditions. The administrative costs would be markedly lower, and it is safe to estimate that only compulsory programs will cover the classes which most need health programs and are presently being used as Exhibit "A" by the advocates of an all-comprehensive national health measure.

The establishment of such soundly conceived state programs would give a defense in depth, now entirely lacking. As happened in the field of unemployment compensation, any subsequent national legislation would almost inevitably be shaped by existing state programs. Again analogizing the developments in the field of unemployment compensation, there would be the distinct probability that direct administration would remain with back-home government, the federal government participating only in a coordinating role.

The time is ripe for medical groups to cooperate with other interested groups, with the end of formulating compulsory prepayment plans that would not appreciably affect the manner and methods of present medical practice. State governments are close and responsive to local needs and interests and are more responsible, politically and administratively, to their citizenry. In these "political laboratories" study and experimentation can proceed apace, unaffected by those who extol the continued extension of governmental power as the panacea for all of our problems. The extollers are exclusively concerned with, and dedicated to, the enactment of national programs.

In line with this general suggestion, state medical groups might well favor, and in any event not oppose, the establishment of state cash sickness benefit programs. Apparently the proposal of such programs in other states has occasioned unjustified apprehension on the part of medicine, simply because of their name. As a matter of fact, there is no direct impact on present medical practice, except through the greater assurance which practitioners would have that their patients were relieved of the worry consequent on complete loss of earning power and were in a better position to meet their doctor bills.

Such a program is now operating in Rhode Island, in close correlation with the state unemployment compensation programs. Basically, such programs are designed to compensate a worker for wage loss occasioned by a non-occupational injury or illness—in much the same manner as unemployment compensation now extends compensation for wage loss due to job failure.

More generally, organized medicine should be considering the roles which state government might properly play in a sound health program. It is not unreasonable to prophesy that a last ditch fight between voluntary versus compulsory programs may well end in the enactment of a national system *a la* Wagner–Murray–Dingell.

Stanley Rector

A WORTHWHILE SURVEY

Within the next few months *every physician* in Wisconsin will receive a questionnaire which is part of a nation-wide survey of child health facilities being conducted by the American Academy of Pediatrics. As it is the purpose of this survey to gather accurate data on the conditions and needs of each state it is highly important that these schedules be filled out and returned promptly. Also it should be emphasized that while some of the questions may seem to be personal in nature the material is to be used in an entirely impersonal manner, and for statistical purposes only.

A few words as to the story behind this study should be of interest to all physicians. The tendency on the part of governmental agencies to expand their activities and encroach on the field of medical practice was noticeable even before the war but has been greatly accelerated since that time. This has caused considerable concern among many physicians and for a time it appeared that there might be an open break between the American Academy and the Federal Bureaus. However, at the November, 1944, meeting of the Academy it was decided that the only logical approach to the whole problem was to make a state-by-state study of all child health facilities; from this to deduce each state's needs; and from this to determine what governmental participation in state programs was desirable.

It is the belief of many members of the Academy that the results of this study will show that the needs and desires of the several states are so varied that they cannot be reduced to one single formula such as is provided in the so-called "Pepper Bill," and that therefore any contemplated Federal legislation must provide for unhampered administration of state programs by state people.—H. K. T.

ATTENTION—ALL COUNCILOR DISTRICTS

Last year the newly organized Council on Medical Service and Public Relations of the Society called on councilors and officers of county medical societies to "arrange annual district meetings with some part of the program on subjects of medical economic significance to which may be invited" representatives of the new council and officers of the State Society.

These are busy days. No one is more aware of that than the physician himself. Yet there are obligations to the profession as a whole that each physician must share if medicine is to continue to serve the public to the best of its ability.

Among those is the interchange of thoughts and problems bearing on the economic side of the practice of medicine as well as those that may be characterized as purely scientific. The Council District Meeting, with a properly balanced program, offers that opportunity. It does more than that, for it supplements informally the information that has been made available to all members through the medium of the *Journal* and printed bulletins.

There is every desire on the part of the elected representatives of the State Society to provide the membership with the fullest information concerning current activities. It can do so only with active cooperation on the part of the whole profession.

A POSTAGE STAMP COSTS 3 CENTS

In recent weeks the *Journal* has been privileged to see two communications from congressional representatives. In one of them the observation was made that "the medical profession has been delinquent in not coming forth with some program which would assure adequate medical attention for persons in financial distress or with low incomes" while the other, in response to a communication from a Wisconsin physician, stated in somewhat similar vein—"it is unfortunate that the country and especially the medical profession has not been aware of the tendency on the part of some people to socialize medicine and to concentrate the responsibility for medical care under the wing of the government."

Those physicians who read this editorial will immediately take issue with both statements. They will remember the extensive and expensive efforts to develop prepaid medical care plans experimentally before seeking their wide application; they will recall the studies made here in Wisconsin and the fight against state medicine or socialization of medicine that began with the first Biemiller bills; and certainly the physicians of Wisconsin know of the work done to extend voluntary health insurance under the plan developed in this state.

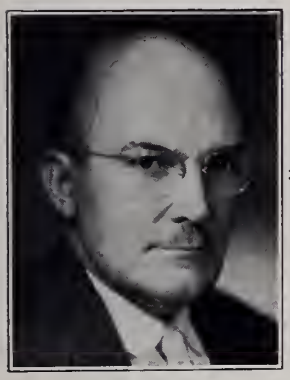
Do the congressmen know? Yes, they have been advised of the position of medicine by officers and others in the profession. But have you written them, seen them at home, talked with their friends and advisors?

As this editorial is being written, the *Journal* has been advised that public hearings on the Wagner–Murray–Dingell bill will begin in April.

A postage stamp costs 3¢. The time has come for the profession of this state and every state to get behind their societies and personally inform their representatives and the public what this is all about, and why the federalization of medicine holds the most harmful implications to the advancement of public health in this country.

The "hasta mañana" policy is obviously worthless.

The Council On Scientific Work Is Pleased to Announce . . .



C. D. NEIDHOLD

H. M. COON

Appreciative of the desire on the part of Wisconsin physicians to revive the postgraduate teaching clinics which were a "wartime casualty" the Council on Scientific Work is pleased to announce that it presents, in cooperation with the Wood, Fond du Lac, and Green County Medical Societies a series of one-day teaching clinics described on the following two pages.

These meetings, planned by Doctor Coon in cooperation with the Council on Scientific Work, are open to members of the State Medical Society as a service to the membership. The registration fee will cover but part of the expenses involved; the balance is being furnished through the treasury of the State Medical Society from funds set aside for professional postgraduate education.

We invite you and your colleagues to participate in these meetings. Teachers well known in their fields have consented to interrupt their busy schedules to provide this service to our members. The entire Council on Scientific Work joins me in expressing its hope that attendance at these meetings will surpass the commendable records established in previous years.

Within the next few weeks each member will receive a special brochure on further details. Advance registrations are urged, so that suitable accommodations can be arranged.

Sincerely,

C. D. Neidhold

Chairman

1946 POSTGRADUATE TEACHING CLINICS

WISCONSIN RAPIDS ★ *Wednesday* ★ JUNE 5

FOND DU LAC ★ *Thursday* ★ JUNE 6

MONROE ★ *Friday* ★ JUNE 7

The Teaching Faculty

NATHAN WOMACK
Washington Univ.
St. Louis, Mo.
Surgery

W. S. MIDDLETON
Dean, U. of W. Medical School
Moderator

W. C. KEETTEL
U. S. War Dept.—Former Consultant, State Board of Health
Obstetrics

F. J. POHLE
Assistant Professor of Medicine, U. of W.
Internal Medicine

JOHN E. GONCE, Jr.
Professor of Pediatrics, U. of W.
Pediatrics

1946 POSTGRADUATE TEACHING CLINICS

A Full Day's Program

MORNING SESSION

9:30–10:00 Registration

10:00–10:40 Toxemias of Pregnancy:
WM. KEETTEL, M. D., *(U. S. War Dept.), formerly associated with State Board of Health.*

10:40–11:20 Diagnosis and Treatment of Hepatic Disorders:
FREDERICK J. POHLE, M. D., *Assistant Professor of Medicine, University of Wisconsin.*

11:20–12:00 Meningitis in Children:
JOHN E. GONCE, JR., *Professor of Pediatrics, University of Wisconsin*

12:00–12:20 RECESS

12:20– 1:00 Pitfalls in Surgical Diagnosis:
NATHAN WOMACK, M. D., *Associate Professor of Clinical Surgery, Washington University, St. Louis, Missouri.*

1:00– 2:00 LUNCH

AFTERNOON SESSION

2:00– 2:20 Clinic: Internal Medicine: Pohle

2:20– 2:40 " : Surgery: Womack

2:40– 3:00 " : Pediatrics: Gonce

3:00– 3:20 " : Obstetrics: Keettel

Arrangements will be made with local physicians to provide actual patients and case findings, with guests giving comments on diagnosis and treatment. In OB possibly a manikin demonstration.

3:20– 3:45 INTERMISSION

3:45– 4:30 Medical motion pictures.

4:30– 5:30 Symposium with each guest speaker speaking on the subject of antibiotics as related to his special field.

5:30– 6:30 Informal social hour.

6:30– 8:30 Round-table dinners.
Discussions will be based on questions raised on the presentations during the morning and afternoon scientific sessions.

Registration Fee

The registration fee of $6 will cover the cost of luncheon, round-table dinner, and participation in the scientific programs presented between the hours of 10:00 a. m. and 5:00 p. m. While registration fees will not cover honorariums and incidental expenses, the balance of the clinic costs will be covered by the State Medical Society and the Bureau of Maternal and Child Care of the State Board of Health. The expenditure of Society funds is provided by the Council as a service to members who desire to participate in the scientific activities of the State Medical Society.

Advance Registrations

In order to retain the essence of a teaching situation all round-table discussions will be limited in attendance. In order to balance attendance all registrants are requested to indicate alternate choices when reservations are made.

Within the next two weeks all members of the State Medical Society will receive reservation slips from the office of the Secretary. The Council on Scientific Work requests that reservations be made promptly by mail, so that adequate dining facilities may be arranged.

Physicians in Service

For many months material in this section was carried under the title of "The Nation at War." With physicians still entering service, with many returning to reestablish themselves in civilian practice, and with many planning to continue in service for an indefinite time, it is the decision of the *Journal* to continue the section under a more timely title.

Returning Veterans

MAURICE HARDGROVE

Dr. Maurice Hardgrove has reopened his private practice in Milwaukee, after serving with the Army Medical Corps since July 1, 1942. Colonel Hardgrove will be officially discharged April 20, 1946.

Serving with the Army–Navy Hospital in Hot Springs, Arkansas, until September, 1942, Colonel Hardgrove then went to Gorgas Hospital in Ancon, Panama, where he was stationed until his return to the states in December, 1945. In November, 1943, Doctor Hardgrove became chief of medical service at the hospital. He wears the Legion of Merit, the American Theater ribbon, and in August, 1945, became a Knight Commander in the Order of Balboa of the Republic of Panama.

Lieutenant Colonel Arthur A. Holbrook of Milwaukee has been discharged from the Army after spending nineteen months overseas. Colonel Holbrook entered the Army June 22, 1942, and was stationed at the Station Hospital, Camp Grant, until July of 1943. Located at Fort Sill, Oklahoma, with the 44th General Hospital until September, 1943, Doctor Holbrook then went overseas and was stationed in Townsville, Australia, until October, 1944, and on Leyte until May, 1945.

Returning to this country, Colonel Holbrook was a lecturer in dermatology in the Pacific Ocean Area Disease Course at Carlisle Barracks, Pennsylvania, until October, 1945.

The doctor wears the Asiatic, Philippine Liberation, American Theater, and Victory ribbons with battle stars for New Guinea and the Philippines.

Major Roy B. Larsen was discharged from the Army March 23. He had been in service since June 7, 1943, having served first at the Camp Grant Station Hospital, and then with the 44th General Hospital at Fort Sill, Oklahoma. Doctor Larsen has returned to the Wisconsin General Hospital.

Captain Alexander S. Hartman of Milwaukee was discharged from the Army December 30, having served in the Hawaiian Islands, on Guadalcanal, New Britain, Luzon, Mindoro, the Philippines, and Mindanao from July, 1942, to June, 1945. After his return to the states, Captain Hartman was stationed at Camp Ritchie, Maryland, and the Fort Sheridan Separation Center. He wears the American Defense, Asiatic–Pacific (with four stars), and the Philippine Liberation (with one star) ribbons.

Discharged from the Navy September 28, 1945, **Lieutenant William J. Houghton** of Milwaukee had served overseas for nineteen months. He entered the Navy in December, 1942, and served at Great Lakes until February, 1943, when he went on duty with the USS Del Brasil, and later with the USS George F. Elliott. Lieutenant Houghton was sent to the Naval Air Facility at Columbus, Ohio, in October of 1944. He wears the Asiatic and American Expeditionary ribbons, with a combat star for Saipan.

Lieutenant Colonel Mischa J. Lustok of Milwaukee was discharged from the Army January 12. He had served in the ETO from August, 1943, to September, 1945, with the 77th Station Hospital and the 144th General Hospital. Colonel Lustok wears the American Defense and European Theater ribbons. He entered the Army February 11, 1941.

Discharged as a major January 18, **Dr. Anton J. Schramel**, Milwaukee, had forty months of overseas service with the 32nd Artillery Division in Australia, New Guinea, Leyte, and Luzon. Major Schramel wears the American Defense, Asiatic–Pacific, and Philippine Liberation ribbons, with campaign stars for New Guinea, Leyte, Luzon, and the Philippines; he also has the Silver Star for gallantry. The doctor entered the Army in October, 1940.

Captain Jack B. Wilets of Milwaukee received his discharge December 1, 1945, after sixteen months of overseas service. He served with the 101st General Hospital in Taunton, England; the 178th in Rheims, France; and the 194th in Antwerp, Belgium. Captain Wilets wears the European Theater ribbon with a star for the Rhineland campaign. He entered the Army March 11, 1944.

Major Hobart W. Johnson, Milwaukee, was discharged March 9 after serving overseas for fifteen months. He was stationed at Camp Callon Station Hospital, California, from September, 1942, to March, 1944. He then went to Ladd Field Station Hospital at Fairbanks, Alaska, and later to the Fort Richardson Station Hospital, Anchorage, Alaska. In July, 1945, he returned to the states and went to the Fort Sheridan Regional Hospital. Major Johnson wears the American Theater, Asiatic–Pacific Theater, Victory, and World War I ribbons.

Dr. Roman E. Galasinski of Milwaukee is on terminal leave from the Navy, having served since October 19, 1942. He was stationed at Bremerton Naval Yards in Washington and with the U. S. Naval Hospital at Camp Lejeune, North Carolina.

Major Robert S. Haukohl of Milwaukee was discharged December 23, 1945, and is now in the pathology department at Marquette University. Major Haukohl entered the Army January 13, 1941, and served with the 135th Medical Regiment at Camp Shelby, Mississippi, until February, 1942; he then went overseas with the unit and served in Australia, New Guinea, New Britain, and the Philippines. Doctor Haukohl wears the American Defense, Asiatic–Pacific, and Philippine Liberation ribbons with five battle stars for the New Guinea, Papuan, Dutch East Indies, Bismarck Archipelago, and Southern Philippines campaigns. He also wears the distinguished unit badge.

R. C. MORRISON

Captain Russell C. Morrison is now at Milwaukee Sanitarium following his release from service. Captain Morrison entered the Army October 30, 1942, and was discharged September 15, 1945. He served at O'Reilly General Hospital, Springfield, Missouri; Harmon General Hospital, Longview, Texas; the Induction Station, Lafayette, Louisiana; and at Camp Hawze, Texas. Doctor Morrison wears the meritorious service emblem.

Captain Leonard J. Schwade was discharged from the Army November 22, 1945, following service with the 128th Evacuation Hospital overseas from September, 1942, until July, 1945. The Milwaukee doctor entered the Army July 14, 1942, and served at O'Reilly General Hospital in Springfield, Missouri, before going overseas. He wears the American and European Theater ribbons with eight bronze battle stars and one arrowhead, for the African, Sicilian, and Normandy invasions.

P. R. CURRER

Captain Paul R. Currer, who had served overseas for eighteen months, was discharged from the Army February 20. He served with the 3rd Infantry Division in France, Holland, Belgium, and Germany, and wears the European Theater ribbon with campaign stars for the Normandy, Northern France, Ardennes, Rhineland, and Central Germany campaigns. Captain Currer entered the Army in August, 1943.

Having served overseas with the Navy for twenty-four months, **Lieutenant Commander Lawrence H. Donath** of Milwaukee was discharged December 31, 1945. He was stationed at the U. S. Navy Yard, Bremerton, Washington, from September, 1942, to January, 1943. Commander Donath's overseas duty included service on the USS Crescent City, January to October, 1943; and on the USS Gilmer, October, 1943, to January, 1945. He then served at the U. S. Naval Special Hospital, Beaumont, California, January to October, 1945. Doctor Donath wears the American Defense and Asiatic–Pacific ribbons with six battle stars.

Major Bruno J. Peters, Milwaukee, was discharged from the Army November 9, 1945, after serving overseas for nineteen months. He entered the service in June, 1942, and was stationed at Camp Adair and Camp White, Oregon, before going to Penley, North Wales, with the 83rd General Hospital. In August, 1945, Major Peters was transferred to the 226th General Hospital in Mourmelon, France. He wears the European Theater, American Defense, and Victory ribbons.

Captain John F. Imp of Milwaukee was discharged from service November 24, 1945; he had been in the Army since March, 1944. Captain Imp was stationed at Lovell Station Hospital, Massachusetts; Camp Grant, Illinois; and served in France with the 288th Medical Detachment from October, 1944, to August, 1945. He wears the European Theater ribbon.

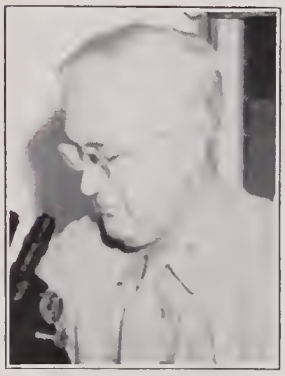
Captain Arthur A. Presti has returned to Milwaukee following his discharge from the Army December 15, 1945. He entered the Army September 25, 1942, and served overseas for fifteen months, with the 80th Fighter Group in India, the 311th Fighter Group in China, Burma, and India, and as Liaison Medical Officer with the 14th Headquarters, AAF, in China. He wears the Asiatic Theater ribbon with four battle stars, and a unit citation.

W. A. RYAN

Captain **William A. Ryan**, Milwaukee, was released from the Navy January 10. He entered the service in February, 1942, and was stationed at San Diego until January, 1943, when he was transferred to the USS Mt. Vernon, in the Pacific. In May, 1943, he went on duty in the Atlantic on the USS Memphis. He returned to Great Lakes in November, 1944, and served there for one year. He wears the American Zone, Pacific Theater, European Theater, and Victory ribbons.

Major John M. Beffel of Milwaukee was released from the Army January 10, having been in service since July, 1942, and overseas for thirty-two months. Doctor Beffel entered the service in July, 1942, and was stationed at O'Reilley General Hospital, Springfield, Missouri, for a month before joining the 15th Evacuation Hospital at Fort Meade, Maryland. He then went overseas with this unit in September, 1942, and participated in the Tunisian, Sicilian, Naples, Foggia, Rome, North Appenines, and Po Valley campaigns.

Major Beffel wears the European–African–Middle Eastern Theater ribbon with five campaign stars, and the meritorious unit badge.



J. P. CONWAY

In service since September 20, 1942, **Commander James P. Conway** of Milwaukee was discharged from the Navy January 27. Commander Conway served with the Naval Medical Unit in Bethesda, Maryland, and with epidemiology units in this country until July, 1944, when he went overseas with the 1st Marine Division.

Commander Conway wears the American Defense, Asiatic–Pacific, and Victory ribbons, the Presidential Division Citation, and the Bronze Star.

Lieutenant Colonel John E. Bentley, Madison, was discharged from the Army January 21. He entered service in 1941 and served with the 44th General Hospital after June, 1942.

Doctor Bentley, who is with the Department of Student Health at the University of Wisconsin, wears the American Theater, Southwest Pacific Theater, Philippine Liberation, and Victory ribbons.

Lieutenant Colonel James M. Sullivan received his discharge January 14, having served in the Army since March 11, 1941. Colonel Sullivan was first stationed at the Station Hospital, Camp Barkeley, Texas. In September, 1942, he joined the 2nd Auxiliary Surgical Group in Atlanta, Georgia, and went overseas with the unit in November of that year, serving in North Africa, Sicily, Italy, France, and Germany. Doctor Sullivan, who is from Milwaukee, wears the Pre-Pearl Harbor and European Theater ribbons with stars for the Tunisian, Sicilian, Naples–Foggia, Rome–Arno, Southern France, Rhineland, and Central Europe campaigns; he also wears the Legion of Merit and the Victory medal.

Captain James C. Sargent was officially discharged from the Navy February 5, following service since March 1, 1942. The Milwaukee doctor served in an administrative capacity at the U. S. Naval Training Station in San Diego until October, 1943; he was then chief of urology at the U. S. Naval Hospital, Shoemaker, California, until July, 1945; at that time he was transferred to Menlo Park where he served as executive to the Senior Medical Officer until October, 1945.

Commander Ignatius J. Ricciardi was discharged March 28, after serving with the Navy since June, 1942, seventeen months overseas. The Milwaukee doctor served in the Office of Naval Officer Procurement there until December, 1943; he was then assigned to the USS President Adams, and later to the USS Pinkney, both in the Pacific. Commander Ricciardi returned to the states and was stationed at Great Lakes, Illinois, from May to November, 1945. He wears the American Defense, Asiatic–Pacific (with four stars), and the Philippine Invasion (with two stars) ribbons.

Captain Erwin J. Jelenchick was discharged from the Army March 19, after serving overseas for sixteen months. The Milwaukee doctor entered the Army in August, 1942, and served with the 2nd Air Force until August, 1944. He then became a flight surgeon and served with the Air Transport Command in the Hawaiian and Gilbert Islands until December of 1945. Doctor Jelenchick wears the Asiatic–Pacific, American Defense, and Victory ribbons.

After twenty-one months of overseas duty with the Navy, **Commander Thomas L. Johnston** of Milwaukee received his discharge December 29. Entering the service September 28, 1942, Commander Johnston served at the Marine Corps Base in San Diego, with the 9th Replacement Battalion at Camp Elliott, California, and then went overseas with the 1st Marine Division in April, 1943. After returning to the states in January, 1945, Doctor Johnston served at Great Lakes, Illinois, until his discharge.

Commander Johnston wears the Pacific Theater ribbon with two stars, and the American Theater and Victory ribbons.

E. W. VETTER

Captain Edward W. Vetter, who practiced in Randolph for two and one-half years before entering service on January 13, 1941, was discharged from the Army February 4. His record of service reads as follows: 135th Medical Regiment, Camp Shelby, Mississippi, Australia, and New Guinea; Percy Jones General Hospital, Battle Creek, Michigan; Mayo General Hospital, Galesburg, Illinois; and Station Hospital, Fort Sheridan, Illinois.

Captain Vetter was overseas from April, 1942, to June, 1944. He wears the Pre-Pearl Harbor, American Defense, Asiatic–Pacific, and Victory ribbons, with three bronze campaign stars and one Presidential unit citation.

Doctor Vetter is now pursuing a postgraduate course in surgery at New York Medical College.

Dr. J. Frampton Wyman of Milwaukee returned from service with the Navy February 1, 1946, and assumed his former position on the staff of the Sacred Heart Sanitarium.

Dr. E. Franklin Carl of Milwaukee, who entered the Army in July, 1942, was discharged with the rank of captain January 2, 1946. Doctor Carl spent over twenty-four months overseas serving with the 304th Station Hospital in England July, 1943, to April, 1944, and with the 16th General Hospital in Liege, Belgium, from April, 1944, to September, 1945. Before going overseas he was stationed at Fort Sheridan. Captain Carl wears the European Theater ribbon.

Lieutenant H. Phillip Dohn, who entered the Navy in August, 1942, plans to return to Milwaukee to locate after June 20, 1946. Doctor Dohn served at the United States Naval Hospital at Great Lakes from August to September, 1942. He was then stationed at Bremerton Navy Yard, Washington, until March, 1943, when he went to Melbourne, Australia, with the 5th Marines Regiment. He wears the American and Southwest Pacific Theater ribbons.

Discharged from the Navy February 27, **Lieutenant Commander Samuel L. Henke** of Eau Claire had served since December 24, 1943. He was stationed at Farragut, Idaho, and San Bruno, California, before going to Oahu, Hawaii, where he served with the Navy #10 Aiea Heights Hospital. Commander Henke wears the American and Asiatic–Pacific Theater ribbons and the Victory ribbon.

Major Theodore H. Joyner, Oregon, received his discharge from the Army March 18. The doctor entered the service September 9, 1943, and served at Carlisle Barracks; with the 363d Medical Battalion, Camp Van Dorn, Mississippi; with the 8th Quartermaster in this country and in England and France; the 25th General Hospital, Tongres, Belgium, and with the 347th Engineers Regiment at Mons, Belgium.

Major Joyner was overseas from January to December, 1945. He wears the Victory ribbons and the European Theater ribbon, with four stars for the Invasion of France, Northern France, Battle of the Bulge, and Rhineland campaigns.

Captain Norman C. Erdmann of Manitowoc was discharged March 24 following service in the Southwest Pacific, the Station Hospital at Camp Ellis, Illinois, and the Percy Jones General Hospital at Battle Creek, Michigan. He wears the American and Southwest Pacific Theater ribbons, the meritorious service medal, and the Victory ribbon. He entered the service July 1, 1943.

Lieutenant Commander George C. Schulte, Kenosha physician, was discharged from the Navy April 10. He had been in service since February 8, 1943, serving overseas from July, 1944, to December, 1945.

After serving at Navy installations at Great Lakes, the University of Missouri, and Chicago, Commander Schulte went to Saipan, serving with the U. S. Navy Military Government Hospital there. He wears the American and Asiatic–Pacific Theater ribbons, with a star for the Mariannas operation.

W. H. SCHULER

Discharged February 13, **Captain William H. Schuler,** formerly of Fennimore, has now opened offices in Ripon. He entered the Army August 10, 1942, and served with the Southeastern Training Command in Alabama and the 3rd Air Force in Tampa, Florida, before going overseas. In November, 1942, he joined the 225th Medical Dispensary unit, serving in North Africa, India, and China. In February, 1945, Captain Schuler joined the 28th Air Service Group in India, and then went to Tinian; there he was later transferred to the 444th Bomb Group, where he remained until November, 1945.

Captain Schuler wears the American, European, and Asiatic–Pacific Theater ribbons, with a battle star for the aerial offensive against Japan, and a Presidential unit citation.

After serving overseas for twenty-four months, **Captain Harold H. Ottenstein** was officially discharged February 22. He entered the Army August 4, 1941, and served with the 28th Medical Training Battalion, Camp Grant, Illinois; AAF Station Hospitals at Victorville, California, and Hobbs, New Mexico; the 108th Medical Battalion, Fort Lewis, Washington; the 259th Quartermaster Battalion in North Africa, Italy, and France; and the 43d General Hospital.

Captain Ottenstein wears the Pre-Pearl Harbor, American Theater, European Theater, and Victory ribbons, with three bronze stars for the Rome–Arno, Southern France, and Rhineland campaigns, and a bronze arrowhead for the Invasion of Southern France.

Back in Milwaukee is **Colonel Forrester Raine**, having been discharged from the Army February 5. He entered service January 15, 1941, and served as Chief of Surgical Service at the Camp Grant Station Hospital until December 31, 1941; he then went to Honolulu in the same capacity with the 147th General Hospital. He was Surgical Consultant for the Central Pacific Area from December, 1942, to June, 1945.

Colonel Raine wears the American Defense and Asiatic–Pacific ribbons.

E. A. BIRGE, II

Lieutenant Colonel E. A. Birge, of Madison, now with the State Laboratory of Hygiene, received his Army discharge December 20, 1945. He had served at the 6th Service Command Laboratory, Fort Sheridan, Illinois; and the 44th General Hospital at Fort Sill, Oklahoma, and later at Townsville, Australia, and Leyte.

Colonel Birge wears the American Theater, Southwest Pacific Theater (with two stars), Philippine Liberation (one star), and the Meritorious Service ribbons, a unit citation, and the Purple Heart. He entered the Army June 18, 1942.

Major Reuben H. Bitter of Oshkosh has returned after five years with the Army Medical Corps. He served with the 12th Cavalry, Fort Bliss, Texas; the 316th Engineers Battalion, Camp White, Oregon; the 276th Infantry, Camp Adair, Oregon; and with the 520th Medical Clearing Company at Camp Bowie, Texas, and in the ETO.

Major Bitter was officially discharged February 13. He wears the European–African–Middle Eastern Theater ribbon with battle stars for the Central European and Rhineland campaigns.

E. T. RECHLITZ

Lieutenant Colonel Erwin T. Rechlitz has located in Amery, following his discharge from the Army November 16, 1945. He was practicing in Milltown prior to entering the service February 11, 1941. He was stationed at Fort Knox with the 12th Armored Replacement Battalion, and at the Randolph Field School of Aviation Medicine, before joining the 38th Bomb Group in December, 1941. With this group he went to Jackson Air Base, Mississippi, San Francisco, Patterson Field, Ohio, and in July, 1942, to Australia, Horn Island, and New Guinea. Further duty in Australia included service with the 5th Air Force and the Far East Air Force. In November, 1944, he went to Orlando, Florida, with the Army Air Forces Tactical Air Center, and later with the Regional Hospital there.

Colonel Rechlitz wears the American Defense and Asiatic–Pacific ribbons.

D. J. TWOHIG, JR.

Lieutenant Colonel David J. Twohig, Jr., Fond du Lac physician, was discharged December 18, 1945, following over three years' service with the Army Medical Corps. He entered service October 23, 1942, served at the Medical Field Service School, Carlisle Barracks, Pennsylvania, until December, 1942, then went to the ETO Office of the Chief Surgeon. Colonel Twohig wears the European Theater ribbon with one battle star, and the Bronze Star.

Major Kenneth E. Lemmer, on terminal leave from the Army until April 21, has been awarded the Bronze Star Medal. He received the honor for continuing to treat patients while his hospital, on Leyte, was under constant enemy fire.

Doctor Lemmer, who entered the Army in June, 1942, plans to return to the University Medical School, where he is an Associate Professor of Surgery.

Major Lemmer was stationed for a year at the Fort Custer Station Hospital before going overseas with the 44th General Hospital Unit, serving in Australia and Leyte.

Major Ervin Hansler, Milwaukee, returned to his practice of medicine February 1. He will be officially discharged from the Army March 17. Major Hansler entered the Army in February, 1943, and was stationed in the United States with the 2nd Air Force until January, 1944. He spent twenty-two months overseas, serving in England with the 55th General Hospital, January, 1944, to July, 1945; the 6th Field Hospital, August, 1945, to October, 1945; and the 14th Port Company in November and December, 1945.

Doctor Hansler wears the European and American Theater ribbons, and the Victory ribbon.

R. V. LANDIS

Lieutenant Colonel Ralph V. Landis, Appleton physician, has returned to practice following his discharge from the Army, November 13, 1945. Colonel Landis went on active duty June 8, 1942, and was stationed at the A.A.F. Regional Hospital at Chanute Field, Illinois, serving as Chief of Surgical Service from March, 1943, until October, 1945. During that time he went on detached service to Harvard Medical School to do work in thoracic surgery, and later to Orlando, Florida, for work in applied tactics.

Major William J. Kelly, Potosi, was discharged December 17 after serving at Camp Joseph T. Robinson, Arkansas, with the Medical Department Replacement Pool, he joined the 30th Division of the 113th Field Artillery. After serving with this unit at various stations, Major Kelly joined the 450th Medical Collecting Company in Camp Forrest, Tennessee, and went overseas with it in December, 1943. This company served in England, Normandy, Belgium, Luxemburg, Holland, and Germany. In January, 1945, Major Kelly became attached to the 13th Field Hospital, serving in Belgium and Holland. In July, 1945, he returned to the states, serving at Billings General Hospital, Fort Benjamin Harrison, Indianapolis, until his discharge.

Major Kelly wears the European and African–Middle Eastern Theater ribbons, with battle stars for the Normandy, Northern France, Ardennes, Rhineland, and Central European campaigns.

Captain Edward T. Hougen has reestablished his general practice in Sheboygan after two and one-half years in the Army. Entering the service June 3, 1943, he was stationed at Carlisle Barracks, Pennsylvania; Jefferson Barracks, Missouri; and Scott Field, Illinois. Captain Hougen was officially discharged March 9.

L. S. SHEMANSKI

Major Leonard S. Shemanski of Appleton, who formerly practiced in Menasha, was discharged January 20. Entering the service July 14, 1941, he first served with the 104th Medical Regiment at Fort Meade, Maryland. In February, 1942, he went to Australia and joined the 33d Surgical Hospital there. Following that he worked with Mobile Hospital #3 on Horn and Thursday Islands, and the 20th Portable Surgical Hospital in Australia, New Guinea, New Britain, Luzon, Panay, and Los Negros. Returning to the United States, he was stationed at Fort Benning for two months before being released from active duty.

He wears the American Defense, Asiatic–Pacific, Philippine Liberation, and Victory ribbons, the Bronze Star and the Presidential citation, and six battle stars for the East Indies, Papuan, New Guinea, Bismark Archipelago, Northern, and Southern Philippines campaigns.

J. B. WEAR

Commander John B. Wear, Madison, was discharged from the Navy February 27. He had served at the U. S. Naval Hospital in San Diego, on the USS Sanctuary in the Pacific, and at the Great Lakes Naval Hospital.

Commander Wear entered service August 12, 1942, and wears the American and Pacific Theater ribbons.

Colonel Carl S. Williamson of Green Bay was officially discharged from the Army Medical Corps March 6. He went on active duty January 2, 1941, and served as surgeon at Losey Field, San Juan, and Boringuen Field, Puerto Rico, from January, 1941, to October, 1945. He wears the World War I, Pre-Pearl Harbor, and American Defense ribbons with one Bronze Star.

Lieutenant Commander Frederick G. Jensen, discharged from the Navy February 21, has resumed his medical practice in Menasha. Entering service June 28, 1943, Commander Jensen was attached to Mobile Hospital #3 in Samoa; spent one year as senior medical officer of the Aviation Repair unit on Guadalcanal; and served on the surgical and orthopedic staffs of Fleet Hospital #105.

J. W. GALE

Colonel Joseph W. Gale has returned to Wisconsin General Hospital, following his release from service November 25, 1945. He entered the Army June 23, 1942, and served with the 44th General Hospital at Fort Custer, Michigan, and Fort Sill, Oklahoma; the Station Hospital at Camp San Luis Obispo, California; and Dibble General Hospital, Menlo Park, California. He wears the American Theater ribbon.

Captain Frank F. Gollin of La Farge was discharged January 2. He entered the Army September 8, 1941, and served with the 987th Field Artillery Battalion at Fort Leonard Wood, Missouri; Mojave Desert, California; and in England, France, Belgium, Holland, and Germany. He then joined the 22d General Hospital in England.

Captain Gollin wears the American Defense, American Theater, Victory, and European Theater ribbons, with bronze stars for the Northern France, Normandy, Rhineland, Ardennes, and Central Europe campaigns, the Bronze Star Medal, and the Oak Leaf Cluster.

Lieutenant Colonel William C. Henske of Chippewa Falls will be officially discharged May 12. He entered service August 4, 1941, and his record of service follows: 104th Medical Regiment, Fort Meade, Maryland; 33d Surgical Unit, Fort Dix, New Jersey, Townsville, Thursday, and Rockhampton, Australia; 41st Division, Brisbane and Sydney, Australia; 4th Replacement Depot at Sydney, Milne Bay, New Guinea, Camp Crowder, Missouri; Percy Jones Hospital, Battle Creek, Michigan; Camp McCoy, and Vaughan General Hospital, Chicago.

Colonel Henske wears the Pre-Pearl Harbor, World Wars I and II, American Defense, and Asiatic–Pacific Theater ribbons, with stars for the East Indies, New Guinea, and Papuan campaigns.

Major Lloyd F. Kaiser, Rhinelander, was discharged December 27, 1945. He entered the Army January 27, 1941, and served with the 5th Medical Supply Depot at Fort Sam Houston, Texas, Camp Ord, California, and Fort Shafter, Oahu; he was stationed at various airfields on Oahu until August, 1945, when he returned to the states. He was then stationed at Randolph Field, and later at Truax Field.

Major Kaiser wears the American Defense ribbon with one star, the American Theater ribbon, and the Asiatic–Pacific Theater ribbon with two stars.

Major Earle E. Kidder, Stevens Point, has returned to practice after completing a twelve-week refresher course at Wisconsin General Hospital. He was discharged October 26, 1945, having been in service since November 5, 1942. Major Kidder was stationed at Camp Bowie, Texas, and Camp Haan, California, with the 13th Field Hospital; at Brentwood, Long Island, with Mason General Hospital; with the 14th Coast Artillery at Fort Worden, Washington; and with the 129th Evacuation Hospital at Camp Carson, Colorado, Fort Riley, Kansas, Scotland, England, France, Belgium, and Germany. Major Kidder was overseas from December, 1944, to August, 1945. He wears the European Theater, American Theater, and Victory (World Wars I and II) ribbons.

J. L. MURPHY

Captain James L. Murphy of Park Falls, who entered the Army August 20, 1942, was discharged January 27. He had served at Randolph Field and Santa Ana, California, at the Schools of Aviation Medicine; Station Hospitals at Hamilton and March Fields, California, and Portland, Oregon; and then joined the 367th Fighter Group, serving overseas with that unit from March, 1944, to September, 1945, at which time he went with the group to Goldsboro, North Carolina.

Captain Murphy wears the European Theater ribbon with six battle stars, the Bronze Star Medal, a unit citation, and an Oak Leaf Cluster.

Lieutenant Commander Leslie G. Kindschi will resume his practice with the Monroe Clinic soon, having been released from active service with the Navy. Commander Kindschi entered the Navy in September, 1943, and served at the Oakland, California, Naval Hospital before going on sea duty in the South Pacific. Returning last summer, he was placed in charge of acute medicine and consultant in cardiac disease at the Great Lakes Naval Hospital.

Lieutenant Commander Howard M. Klopf of Milwaukee is on inactive duty and will be discharged from the Navy May 2. He began active duty at the U. S. Naval Hospital, Chelsea, Massachusetts, on April 20, 1942; served as medical officer aboard the USS Upshur; was stationed at USN Receiving Barracks, Shoemaker, California; Puget Sound Navy Yard, Bremerton, Washington; and served as medical officer at the U. S. Naval Station at Astoria, Oregon.

R. E. SCHRANK

Captain Raymond E. Shrank has returned to practice in Waupun following his release from service. He entered the Army March 3, 1944, and served in the Army General Hospital near Kington, in southwestern England, for a year.

Lieutenant Commander Desmond H. Callaghan returned to Hayward and reopened his office February 18. His terminal leave expired March 25. Commander Callaghan entered the Navy October 23, 1942, and was stationed at North Island Aid Station and Family Hospital, California. He went overseas in June, 1943, and served for eighteen months as commanding officer of a Marine hospital unit. After his return to the United States, he was stationed at the U. S. Naval Hospital at Corvallis, Oregon.

Commander Callaghan wears the Asiatic–Pacific Theater ribbon with three battle stars, the American Defense, and the Victory ribbons.

Major Clarence H. Buckley, recently returned from Europe, has reopened his office in Menomonie. He entered the Army July 20, 1942, and was recently discharged.

Lieutenant Colonel Michael F. De Salvo, formerly with the Jackson Clinic at Madison, has returned to civilian life and to work with the clinic, after having served almost five years in the Army Medical Corps.

On entering the service January 17, 1941, Doctor De Salvo was assigned to Camp Livingston, Louisiana, where he remained on duty for seven months. In August of that year he was transferred to Keesler Field, Mississippi, where, as medical inspector for two and one-half years, he supervised the public health measures and sanitary conditions at the military reservations in that area and, with the state and county authorities, improved civilian sanitary conditions.

In May, 1944, he was ordered to the Panama Canal Zone where he remained on duty for eighteen months during which time he was appointed Malaria Control Officer for the Panama Canal Department.

Doctor De Salvo returned to the United States and was released from active duty with the Army on November 28, 1945; his terminal leave ended March 28.

Captain John V. Flannery of Wausau received his discharge January 13, having been in military service since September 8, 1942. Serving with the 50th Medical Battalion, he was stationed in Texas, England, France, Belgium, and Germany. Returning to this country in June, 1945, Captain Flannery was stationed at Vaughan General Hospital, Hines, Illinois. He wears the American Theater, Victory, and European Theater ribbons, with bronze stars for the Normandy, Northern France, and Germany campaigns, and a bronze arrowhead for the Normandy amphibious invasion.

Captain H. A. Frank, Milwaukee, was discharged from the Army December 7, 1945; he had been in service since August 26, 1943. Serving first with the 1101st Combat Engineers at Camp Shelby, Mississippi, and then with the 301st Ordnance Battalion at Camp Livingston, Louisiana, Captain Frank then went overseas with the 616th Clearing Company, serving in Africa, Anzio, and France; he also was stationed in Germany.

Captain Frank wears the European Theater ribbon with battle stars for the Rome–Arno, Southern France, Central Europe, and Rhineland campaigns, and an arrowhead for the Invasion of Southern France.

Captain John R. Talbot has opened an office in Wonewoc, following his discharge from the Army April 1. He entered the Army December 9, 1940, and was assigned to the Army hospital at Fort Riley, Kansas, as an attending surgeon, and later to Camp Crowder, Missouri. Overseas he was stationed in New Guinea, serving as commanding officer of the hospital unit at Oro Bay. He served with the 12th Portable Surgical Hospital at Biak, then went to Mindoro, and participated in the campaigns at Zamboanga and the Sulu Archipelago, and the occupation of Japan, being stationed at Huro Honshu.

T. A. LEONARD

Commander Thomas A. Leonard writes, "Soon I will be returned to inactive status and will resume my practice in Madison. I expect to be there sometime during early April." Commander Leonard entered the Navy October 1, 1943.

Captain Gordon W. Brewer of Hartland was discharged December 3, 1945. He had been in the Army since May 20, 1942. He first served at Geiger Field, Spokane, and then with the Schools of Aviation Medicine at Randolph Field, Texas, and Santa Ana, California. He was then stationed with the 450th Bomb Group in Manduria, Italy.

Captain Brewer wears the European Theater ribbon with ten battle stars, a unit citation, and one cluster.

W. D. JAMES

Lieutenant Colonel William D. James, discharged January 13, has returned to his practice in Oconomowoc. He entered service March 17, 1941, and served in station hospitals at Fort Sill, Oklahoma, and Camp Wolters, Texas, before joining the 147th Engineers (C) Regiment at Camp Swift, Texas. There he was transferred to the 1117th Engineers (C) Group, serving with it in the ETO. Colonel James wears the American and European Theater ribbons, the American Defense and Victory ribbons, the Bronze Star Medal, and battle stars for the Northern France, Normandy, Rhineland, and Central European campaigns.

Captain Stephen A. Konz of Appleton received his discharge December 3, 1945. He had been with the Army Medical Corps since November 21, 1942, and was first stationed at the Camp Grant Station Hospital. He went to England in September, 1943, and served with the 232d Station Hospital until July, 1945. From that time until his separation from service, Captain Konz was stationed with the 65th General Hospital. He wears the European Theater ribbon.

Lieutenant Colonel Allen L. Millard has returned to the Marshfield Clinic. He was discharged December 31, 1945, having served since January 6, 1941. Colonel Millard was regimental surgeon with the 2d Infantry Regiment at Fort Custer, Michigan, and then in Iceland. He was then stationed at Camp Vannin with the 8th Service Command Station Hospital. Colonel Millard wears the Pre-Pearl Harbor and European Theater ribbons.

Major Reginald W. Hammond has returned to Manitowoc after being discharged from the Army February 11. He entered the Army January 1, 1943, and was stationed at the Regional Hospital, Camp Swift, Texas.

M. F. HUTH

Lieutenant Colonel Melvin F. Huth of Baraboo received his discharge January 14, following five years' service with the Army. Colonel Huth served with the Medical Replacement Training Center at Camp Grant, Illinois, until November, 1942, when he joined the 103d Infantry Division, serving with it in Louisiana, Texas, and the ETO. In July, 1945, he was transferred to the 45th Infantry Division. Colonel Huth wears the American Defense and European Theater ribbons, with a bronze star.

Major R. C. Groendahl, discharged from the Army Medical Corps March 2, has returned to the clinic at Seymour. He served for forty-four months, thirty-one of them in the Southwest Pacific. Commissioned June 12, 1943, he was assigned to the 3d Field Hospital for training at Camp Young, Indio, California. While overseas Major Groendahl was stationed in Australia, New Guinea, Leyte, and Luzon.

Lieutenant Colonel Marvin F. Greiber has returned to the University of Wisconsin Medical School. He entered service December 2, 1942, and was discharged November 29, 1945. He served with the 111th Station Hospital at Camp Wheeler, Georgia, and went overseas with the outfit in September, 1943, to Assam, India. In October of 1944 he transferred to the 234th General Hospital, also in Assam. Colonel Greiber wears the American Theater, Asiatic–Pacific Theater, and Victory ribbons.

Discharged from the Navy February 13, **Lieutenant Commander Leonard S. Markson**, Milwaukee, had served since August 13, 1942. He was stationed at Great Lakes until November, 1942, when he began service on the USS Rixey, in the Pacific Theater. In December, 1944, Doctor Markson was transferred to the naval hospital at Astoria, Oregon, and in October, 1945, to the one in Chelsea, Massachusetts.

Commander Markson wears the American Waters, Asiatic–Pacific (with two stars), Philippine (with two stars), and Victory ribbons.

Lieutenant Colonel Marshall W. Alcorn, formerly of Burlington, was discharged February 12, and will be located in Bay City, Michigan, after May 1. He entered the service February 2, 1943, and was stationed at Bruns General Hospital, Santa Fe, New Mexico, before going to Luzon in the Philippines with the 89th Field Hospital. After serving there

from November, 1944, to October, 1945, he went to Biak Island to the 17th Station Hospital, where he remained until January, 1946. Colonel Alcorn wears the American and Asiatic–Pacific Theater, Philippine Liberation, and Victory ribbons.

Major Clement J. Moran, formerly of La Crosse, has located in Burlington following his release from service February 19. Entering the Army October 15, 1940, Major Moran served with the 120th Field Artillery in Livingston, Louisiana, until February, 1942, when he went to New Guinea with the 128th Infirmary; he subsequently served as Transport Surgeon on the SS Cefala, and as Leave Area Surgeon at Sydney, Australia. Returning in February, 1945, Major Moran served at the Military–Civilian Affairs School at Yale University until August.

Doctor Moran wears the Pre-Pearl Harbor, Southwest Pacific, and Combat Surgeon's ribbons, with battle stars for the Buna and Papuan campaigns.

Recent Releases From Service*

Physicians and Location	*Date Discharged*
Alcorn, M. W., Burlington	February, 1946
Beattie, J. W., Delavan	January, 1946
Behnke, C. H. Oshkosh	March, 1946
Brady, C. J., Lake Geneva	January, 1946
Brick, E. B., Wausau	March, 1946
Christensen, H. W., Wausau	March, 1946
Clark, C. J., Fond du Lac	March, 1946
Erdmann, N. C., Manitowoc	March, 1946
Greiber, M. F., Madison	November, 1945
Groendahl, R. C., Seymour	March, 1946
Gutheil, D. A., Wauwatosa	January, 1946
Hannan, K. D., Prairie du Sac	February, 1946
Hardgrove, Maurice, Milwaukee	April, 1946
Harrison, G. W., Ashland	April, 1946
Hathaway, G. J., Superior	January, 1946
Heiden, H. H., Sheboygan	January, 1946
Helmbrecht, M. G., Elkhorn	February, 1946
Hougen, E. T., Sheboygan	March, 1946
Hudson, E. D., Lake Geneva	February, 1946
Jensen, F. G., Menasha	February, 1946
Kleis, W. J., Milwaukee	January, 1946
Kohler, H. H., Sheboygan	January, 1946
Kroyer, T. J., Walworth	February, 1946
Kuhn, R. V., Oshkosh	March, 1946
LaBreche, J. J., Stanley	January, 1946
Lahmann, A. H., Milwaukee	March, 1946
Langmack, W. A., Brillion	February, 1946
Larsen, R. B., Madison	March, 1946
Levin, H. M., Darien	March, 1946
Mayer, R. G., Madison	April, 1946
McLaughlin, W. J., Wrightstown	February, 1946
McRoberts, J. W., Sheboygan	December, 1945
Petersen, G. W., Neenah	August, 1945
Piaskoski, Ray, Milwaukee	January, 1946
Pierce, D. F., Hales Corners	April, 1946
Puttler, O. L., Mauston	March, 1946
Rastetter, J. W., Milwaukee	January, 1946
Schlomovitz, H. H., Barron	January, 1946
Schott, E. G., Sheboygan	February, 1946
Schulte, G. C., Kenosha	April, 1946
Seelman, A. G., Milwaukee	January, 1946
Smits, R. H., Milwaukee	March, 1946
Strand, R. C., Eau Claire	November, 1945
Talbot, J. R., Marshfield	April, 1946
Thatcher, D. S., Milwaukee	January, 1946
Vande Loo, F. B., Brillion	April, 1946
Weeks, F. D., Ashland	February, 1946
Weinshel, L. R., Milwaukee	February, 1946

* Members of the State Society listed in boldface.

VETERAN PHYSICIANS' EXCHANGE

This page will be devoted to a classified section, open without charge to: (a) veteran members desiring location and (b) other members having professional openings suitable for men returning from military service.

LOCATIONS WANTED

LOCATION WANTED: Young orthopedist, completely trained in both reconstructive and traumatic surgery, desires industrial or group practice connection in or near Milwaukee. Available after July 1, 1946. References exchanged on request. Address No. 100 in care of the Journal.

WANTED: Location or association with physician in S. W. United States. Age 39 years. Class A graduate Ten years active civilian and military experience, including surgery. Address No. 102 in care of the Journal.

LOCATION WANTED: General practitioner, 36, will purchase practice, home, etc.; available May 1, 1946. Can arrange personal interview immediately. Address No. 103 in care of the Journal.

LOCATION WANTED: Pediatrician, 32, protestant, married, graduate Class A school, 4 years hospital training, eligible for certification by American Board, Wisconsin state license, on terminal leave after 3½ years naval service, desires location or association with practice limited to pediatrics. Available after March 15. Address No. 111 in care of the Journal.

DESIRE GENERAL PRACTICE in town 5,000–25,000 anywhere in Wisconsin with good hospital facilities. Have much of own medical equipment from previous general practice. Over 3 years service in U. S. Public Health Service with wide variety of general practice especially in internal medicine, general surgery, psychiatry, and eye work, especially refractions. Must have housing for wife and three children. Would consider partnership with older doctor who does own general surgery. Would also consider joining clinic. Address No. 112 in care of the Journal.

WANTED ASSOCIATION with a clinic group or another orthopedist. 3 years residency completed in orthopedics in mid-west university. 1st part of American Board of Orthopedics exam passed. Available in June. Address No. 113 in care of the Journal.

LOCATION WANTED: I have had a limited experience in general surgery, internship and residency. Experience as surgeon in native hospital while in service. Desire location with ample training facilities to enable eventual board application, assisting reputable surgeon, or general practice with surgical opportunity. Address No. 122 in care of the Journal.

ASSISTANCE WANTED

PHYSICIAN WANTED: Village of 1,200. Fourteen miles to three hospitals. No competition. Farming community. Office space available. Address No. 108 in care of the Journal.

WANTED: Man to take over my home in town of 500. All modern, cost $14,000; will sell for $6,000. Oil burner, 2-car garage, redecorated. Modern office with $2,000 improvements; 8 rooms. Office rent $30, ground floor. Doctor to run office, and work with a three-man clinic 7 miles away in town of 4,000 with modern hospital. Clinic to be formed and new building to be built soon. Address No. 104 in care of the Journal.

WANTED: Southern Wisconsin Clinic needs energetic M. D., general work, surgical, obstetrical, medical and industrial. Good opportunity for permanent position. Address No. 105 in care of the Journal.

PHYSICIAN WANTED: About March 1 to take over a well established practice in a prosperous lumbering and farming community. Fully equipped office with x-ray equipment and a heated residence furnished. No cash outlay required when starting. Address No. 106 in care of the Journal.

ASSISTANT WANTED: General practice, surgical training, with prospective partnership. Address No. 107 in care of the Journal.

WANTED: Assistant in a large general surgical and medical practice by physician in city of two thousand, having a 20-bed community hospital, in prosperous farming community in midwestern Wisconsin. Must be willing to do some surgery and obstetrics. Full partnership after one year, if conditions satisfactory. Salary determined by amount of experience. Fully equipped office including fluoroscope, x-ray, BMR, EKG, etc. Address No. 109 in care of the Journal.

DOCTOR WANTED: The doctor who practiced here for over 50 years recently died. There is a modern house, water, bath, etc.; excellent double garage, can be heated; office attached to house, small waiting room and small drug room, no modern equipment. Good will of the community goes with opportunity. Address No. 114 in care of the Journal.

ASSOCIATE DESIRED: To do internal medicine and pediatrics. Also required to assist in major surgery. Excellent opportunity in a good community which has a well-equipped 60-bed hospital. Applicants must have had postgraduate training in internal medicine or pediatrics. Address No. 115 in care of the Journal.

ASSISTANT WANTED: Recent graduate or discharged medical officer, preferably single, protestant, and particularly interested in going general practice in prosperous small town. Present gross income over $20,000 and more work available than can be handled satisfactorily by one active doctor since recent additions of factories, etc. Hospital connections nearby; housing facilities at present only drawback. Address No. 123 in care of the Journal.

WANTED YOUNG PHYSICIAN: With ability to do general surgery, to be associated with busy general practitioner, in central Wisconsin area. Population of city over 2,000. Unlimited opportunity for right man. Address No. 116 in care of the Journal.

WANTED ASSISTANT leading to partnership; busy general practice, considerable obstetrics and gynecology. Central Wisconsin city of 35,000 with excellent hospital facilities. Prefer young married doctor. Salary open. Address No. 118 in care of the Journal.

OPPORTUNITY: In town of 10,000 for returning veteran with some training in internal medicine to joint clinic in department of dermatology and allergy, to work chiefly with general allergies. Opening for permanent position; applicants for temporary position also considered. Clinic composed of 16 doctors, all members of respective specialty boards. Address No. 119 in care of the Journal.

FOR SALE OR LEASE: Retiring physician's modern house including five-room fully equipped office in thickly populated part of Milwaukee. Fine opportunity for young energetic physician with surgical and general medical experience. It is also suitable for a group. Rental income from the property pays taxes and upkeep. The sale requires $10,000 cash—balance easy terms. Would lease ONLY the office to a suitable party. Address No. 121 in care of the Journal.

FOR SALE: $28,000 property; four apartments besides own 5-room and 4-room offices. Garage in basement. Located on corner of 18th and Wells Streets in heart of Milwaukee medical center. Children's Hospital and Curative Workshop near; one block to Deaconess, three blocks to Marquette University, five blocks to Milwaukee Hospital, Mt. Sinai, etc. Ten blocks to heart of city. Could use dentist with myself or whoever buys the place, or splendid clinic location. Address No. 110 in care of the Journal.

VETERAN PHYSICIANS: This is a strategic time to enter public health. State Board of Health has 2 openings for physicians with executive ability as directors of the tuberculosis and venereal disease divisions. Salary $4,800 to $5,400 plus necessary traveling expenses, Madison headquarters. 5 district health officers also needed. If you were under 40 when entering the armed services and can otherwise qualify, write Dr. Carl N. Neupert, State Health Officer, Madison 2, Wisconsin.

SUBURBAN PRACTICE: Unusual opportunities in La Crosse. Office space available and help in contacts. See ad on page 458 for details.

WANTED: Staff physician at sanatorium approved for tuberculosis residency. Beginning salary $250–$300, less modest maintenance deduction. One position open July 1, another probable the last of March. Wisconsin licensure required. Person must have good professional and personal qualities. Write Superintendent, Wisconsin State Sanatorium, Statesan, Wisconsin.

WANTED: Returning veteran for general work in town of 5,000. General hospital and complete office available. Address No. 117 in care of the Journal.

For additional classified advertisements, see the Physicians' Exchange, page 458

"SMOOTHAGE" FOR THE CONVALESCENT

By promoting normal peristalsis without irritating the delicate mucosa, Metamucil is particularly desirable for treating the constipation of hospital patients.

Metamucil provides "smoothage" . . . a modern concept for the treatment of constipation. It does not interfere with digestion or absorb oil-soluble vitamins. It is rapidly miscible, pleasantly palatable.

Metamucil is the highly-purified, nonirritating extract of the seed of the psyllium, Plantago ovata (50%), combined with dextrose (50%). In 1-lb., 8-oz. and 4-oz. containers.

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News Items and Personals

In Commemoration

The following resolution was presented by Dr. L. W. Beebe, Superior, and adopted by the Douglas County Medical Society:

Through the Douglas County Medical Society it has devolved on me to memorialize on the passing of the late Dr. C. H. Mason. Doctor Mason was born at Eau Claire, Wisconsin, May 4, 1873, where he grew up under the care of his aunt, his mother having died at the time of his birth. He attended the grade and high schools of Eau Claire.

While attending school he worked at various jobs during his evenings to help out in his support. Later he worked his way through college. During his vacations, he played baseball and various other vocations to raise money for his college tuition and other expenses. While at college, to save room rent, he was a night attendant at one of the mortuaries in Minneapolis. Doctor Mason was largely a self-made man and one cannot help in admiring his persistence in obtaining an education. He graduated in 1898 at Hamlin University Medical School, which was later absorbed by the University of Minnesota. His first two years in practice were somewhat varied. For a short time he served in the United States Army as surgeon in companies sent to Western Minnesota from St. Paul to quell an uprising of Indians. He was appointed railroad surgeon of the Great Northern Railroad at Walker, Minnesota. Later he formed a partnership with Doctor Wigg at Clinton, Minnesota, where Doctor Wigg had established a hospital. The practice was very fatiguing with calls in many instances forty to fifty miles from Clinton. They kept three teams and two drivers busy. While the business was very remunerative, Doctor Mason felt that he did not desire to continue in such a fatiguing practice.

In the year 1900 he married and came to Superior on his wedding trip. He decided to locate in Superior which was a growing city although it had just passed through the great boom of the nineties. Doctor Mason soon built up a large practice and was a busy physician up to the time of his health failing about eight years ago.

Doctor Mason was a very charitable man and several years, during the Christmas holidays, he would buy clothes, food, and candies and he and Mrs. Mason, on Christmas Eve, would distribute them where they would give cheer to many worthy poor families. He gave freely to his church, the Concordia Lutheran Church, and at one time was president of the congregation. He was a very active member and was chairman of the building committee at the time the new church was built.

Doctor Mason was former Chief of Staff of St. Joseph and St. Mary's Hospitals and served as president of the Douglas County Medical Society and the Inter Urban Academy of Medicine and a member of the State Medical Society and also the American Medical Association. He was a member of the Shrine and other Masonic organizations, the Sons of Norway, and Scandinavian American Fraternity. He was Past Chief Examiner and Trustee of the Grand Lodge of the last named order. In 1918, he was placed in charge of medical relief of the fire sufferers during which time he gave several weeks of his time without compensation. Doctor Mason was past president and honorary member of the Douglas County Medical Society for forty-five years and as such was an outstanding example to other members of our profession. His career in medicine covered the transition from the old family doctor traveling by horse and buggy, to the present day of specialization in medicine and travel by automobile and airplane. Doctor Mason was a definite part of this transition. I suggest the following resolutions:

Resolved, That the Douglas County Medical Society, hereby enter into the minutes of this meeting the sincere condolence of this society to Mrs. Mason in the loss of our old member, Charles H. Mason.

Now, therefore, be it further resolved that, Since the Almighty, in his infinite wisdom saw fit to call our departed practitioner from our little circle to his heavenly reward, we, the members of the Douglas County Medical Society, do, hereby, extend our sincere sympathy to the members of his family in their hour of tribulation, with the satisfaction of knowing that the word of our Lord may justly be said to him—"Well done, thou good and faithful servant."

Be it further resolved, That copies of these resolutions be prepared and sent to Mrs. Mason and his brother, Harold Mason, at Wadena, Minnesota.

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Dr. L. A. Copps was among the fifteen directors of the new Marshfield Chamber of Commerce, selected by a mail ballot, it was announced February 22.

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Dr. Philip A. Panetti, postmaster in Hustisford for eleven years, has retired from the postal service. He has been practicing medicine there since 1888.

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At a luncheon meeting held Friday, March 2, nineteen physicians who lecture at the central school of nursing education at the Milwaukee Vocational School were honored. Among them was *Dr. Max J. Fox,* who has completed twenty years of lecturing there.

—△—

Dr. A. E. Kuehn has returned to La Crosse from California, where he just completed a special course in the study of the eye, ear, nose, and throat.

The First Year

THE SUCCESSFUL NUTRITIONAL history of S-M-A babies is due to the remarkable similarity of S-M-A to mother's milk. It is essentially the same as human milk in percentage of protein, fat, carbohydrate and ash, in chemical constants of the fat and in physical properties.

S-M-A* IS RECOMMENDED for normal, full term infants in the early weeks of life when a supplementary food is required for the breast-fed infant. It may be given to infants of any age whenever the mother's milk is unavailable, of poor quality or insufficient quantity.

S-M-A is derived from the milk of tuberculin-tested cows. Part of the butter fat of this milk is replaced with animal and vegetable fats, including biologically assayed cod liver oil. Milk sugar, vitamin A and D concentrate, carotene, thiamine hydrochloride, potassium chloride and iron are added. *REG. U. S. PAT. OFF.

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Dr. Donald W. Hastings, former chief psychiatrist of the 8th Air Force in England and later chief air force psychiatrist in Washington, has been appointed by the University of Minnesota Medical School Board of Regents, Minneapolis, as professor and head of the department of neuropsychiatry in the medical school, effective March 16. Doctor Hastings will fill the vacancy left by the illness and resignation of Dr. John C. McKinley. Since his release from the Army in August, 1945, Doctor Hastings has served as professor of psychiatry at the Women's Medical College of Pennsylvania in Philadelphia. He graduated from the University of Wisconsin Medical School in 1934.

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College of Surgeons Clinical Congress

The Thirty-second Clinical Congress of the American College of Surgeons will be held at the Waldorf–Astoria in New York September 9 to 13. Included in the program will be demonstrations, scientific sessions, panel discussions, symposia, forums, Hospital Standardization Conference, medical motion pictures, business meetings, and educational and technical exhibits.

The first clinical congress since the 1941 meeting in Boston, this one will feature formal initiation ceremonies for the 2,744 surgeons who have been received into fellowship in absentia during that time.

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University of Illinois Announces Refresher Courses

A one week didactic and clinical refresher course in otolaryngology has been arranged for specialists in the field, from May 13 to 18, 1946, at the University of Illinois College of Medicine. Applications for registration should include school of graduation, training, and experience. Check for tuition ($50) should accompany the application.

In addition, a special course in Broncho-Esophagology will be given from June 3 to 15, 1946. It will consist of lectures, animal and cadaver demonstrations, diagnostic and surgical clinics, under the direction of Drs. Paul H. Holinger and Albert H. Andrews, Jr. Tuition for this course is $100. Check should accompany application. This class is limited to twelve physicians.

For further information address: Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago, Illinois.

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Fellowship Examination Announced

The next oral and written examinations for fellowship in the American College of Chest Physicians will be held at San Francisco on June 29, 1946. Applicants for fellowship in the college who plan to take the examination should communicate with the Executive Secretary, American College of Chest Physicians, 500 North Dearborn Street, Chicago 10, Illinois.

The Twelfth Annual Meeting of the college is scheduled to be held at the Sir Francis Drake Hotel, San Francisco, June 29 to July 2, 1946.

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Obstetrics and Gynecology Board Examination

The general oral and pathology examinations (Part II) for all candidates to the American Board of Obstetrics and Gynecology, Inc., will be conducted at Chicago by the entire board from May 6 through May 11, 1946. The Palmer House will be the headquarters for the board. Formal notice of the exact time of each candidate's examination will be sent him several weeks in advance of the examination dates. Hotel reservations may be made by writing direct to the Palmer House.

Candidates for reexamination in Part II must make written application to the Secretary's Office not later than April 15, 1946.

Candidates in military or naval service are requested to keep the Secretary's Office informed of any change in address. Deferment without time penalty under a waiver of our published regulations applying to civilian candidates, will be granted if a candidate in service finds it impossible to proceed with the examinations of the board.

Applications are now being received for the 1947 examinations. For further information and application blanks, address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh 6, Pennsylvania.

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Marquette Medical Alumni Spring Clinic

The Annual Spring Clinic of the Marquette Medical Alumni Association will be held at the Marquette University Medical School Auditorium, Milwaukee, on the afternoon of May 1, 1946. The speakers and their topics for discussion will be: "Progress of Medicine," Dr. F. G. Hirschboeck, Duluth, Minnesota; "Abdominal Wounds of World War II," *Dr. James M. Sullivan*, Milwaukee; "History of Medicine," *Dr. J. S. Hirschboeck*, Milwaukee; "Representation of Marquette Medical Alumni in War," *Dr. C. K. Ziegler*, Milwaukee.

The Spring Clinic will follow the annual Alumni Dinner at the Ambassador Hotel, at which the present senior class of the Marquette Medical School will be guests.

★ *The Office of the State Medical Society has available loan packets for lay or professional use on the subject of the Wagner–Murray–Dingell Bill and related matters.*

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Among the structural advantages of the Root Tachistoscope are its built-in light sources using standard, easily obtainable bulbs and a time shutter with speeds up to 1/400 second.

Society Proceedings

Brown—Kewaunee—Door

Resumés of travels and experiences while in the military service by returned members of the Brown–Kewaunee–Door County Medical Society were the main feature of the March 14 meeting of the society. Service members present were: *Captain K. J. Denys, Captain V. S. Falk, Lieutenant Commander K. R. Icks, Lieutenant F. O. Kuehl, Major S. M. Mokrohajsky, Captain J. S. Feurig, Major R. J. Rose, Major C. S. Bolles, Major O. W. Saunders,* and *Lieutenant Colonel C. S. Williamson.*

Chippewa

Meeting at the Hotel Northern in Chippewa Falls on Friday, February 22, the Chippewa County Medical Society was addressed by two University of Minnesota professors of surgery. Dr. John R. Paine discussed "Benign Stricture of Common Bile Duct," while Dr. Richard L. Varco's subject was "Dietary Perforation for Substandard Risk Surgical Patients."

Drs. Lyman W. Picotte and *Earl Hatleberg* were named to a Cancer Committee by the president.

Crawford

At a recent meeting of the Crawford County Medical Society the following officers were elected for 1946: *Drs. E. M. Dessloch,* president; *O. E. Satter,* vice-president; *T. F. Farrell,* secretary-treasurer; and *G. R. Hammes,* delegate. All the doctors are from Prairie du Chien except Doctor Hammes, who is from Seneca.

Dodge

Meeting at the Lutheran Deaconess Hospital in Beaver Dam on Thursday, March 21, the Dodge County Medical Society was addressed by *Dr. Chester M. Kurtz* of Madison, speaking on Rheumatic Fever.

Eau Claire—Dunn—Pepin

The Eau Claire–Dunn–Pepin County Medical Society met at the Elks Club on Monday, February 25. *Dr. G. L. McCormick* of Marshfield discussed "Cancer Detection Centers."

Fond du Lac

At the regular monthly meeting of the Fond du Lac County Medical Society, held at the Hotel Retlaw in Fond du Lac on Thursday, February 28, *President P. R. Minahan* of the State Society discussed the subject of voluntary and compulsory health insurance. A brief report on the forthcoming federal legislation regarding health insurance was given by Secretary Crownhart.

Iowa

Members of the Iowa County Medical Society were guests of the Kiwanis Club at a meeting held Monday, March 4. The group was addressed on the subject of compulsory health and sickness insurance.

Jefferson

Dr. E. W. Bowen of Watertown gave a "Resumé of the Literature on Psychoneurosis" at the February 21 meeting of the Jefferson County Medical Society, held at the Cottage Hotel in Lake Mills.

La Crosse

At their February 12 meeting the La Crosse County Medical Society heard Dr. Theodore Fritsche of New Ulm, Minnesota, speak on "Common Diseases of the Eye."

The speaker of the evening at the March 12 meeting was Dr. Charles Slocumb of the Mayo Clinic; his subject was "Newer Developments in the Treatment of Arthritis and Rheumatic Fever."

Marathon

At a dinner meeting of the Marathon County Medical Society, held in the Hotel Wausau on Wednesday, February 27, *Dr. Joseph F. Smith,* Wausau physician and surgeon and president of the medical staff of St. Mary's Hospital, was honored. He was presented with a gold wrist watch as a memento of the occasion. *Dr. Erwin R. Schmidt* of Madison, Chief of Surgical Service at the University of Wisconsin Medical School, spoke on "Advancing the Frontiers of Surgery." A brief discussion of "The Wisconsin Plan" was presented.

Trempealeau—Jackson—Buffalo

The Trempealeau–Jackson–Buffalo County Medical Society was entertained in Galesville by *Drs. R. L. Alvarez* and *H. A. Jegi* at a dinner meeting held Thursday, February 21. *Drs. B. R. Walske* and *B. C. Dockendorff,* both practicing in Arcadia since their recent releases from service, were the speakers. They spoke of their experiences as medical officers in the Pacific Theater of Operations, and Doctor Walske showed pictures of the destruction of Manila.

Milwaukee

A memorial address in honor of the late professor of pathology at Marquette University School of Medicine, *Dr. John Grill,* was featured at a meeting of the Medical Society of Milwaukee County, held at the Athletic Club on Friday, March 8. *Dr. Paul*

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Klemperer, clinical professor of pathology at the Columbia University College of Physicians and Surgeons, spoke on "Clinical and Pathological Aspects of Allergy and Lupus Erythematosus."

Outagamie

Meeting at the Conway Hotel, Appleton, on Thursday, March 21, the Outagamie County Medical Society heard a talk on "Anti-Coagulant Therapy" by *Dr. Ovid O. Meyer* of Madison. His presentation was illustrated with slides.

Walworth

At a business meeting held at the Colonial Hotel in Delavan on Thursday, March 14, the Walworth County Medical Society elected the following officers for the year: *Drs. Charles J. Brady*, president; *Edward D. Hudson*, vice-president; and *H. F. Bischof*, secretary-treasurer; all are from Lake Geneva.

Washington—Ozaukee

After enjoying a turkey dinner, members of the Washington–Ozaukee County Medical Society, meeting at The Cedars in Cedarburg on Thursday, February, 28, heard *Dr. Harold W. Shutter*, of Milwaukee discuss the "Rh Factor in Obstetrics" and "Ovarian Disfunction."

Waukesha

Dr. Paul E. Campbell of Waukesha spoke on "Choice of Anesthesia" at the February 6 meeting of the Waukesha County Medical Society, held at the Waukesha Memorial Hospital.

Winnebago

The March 7 meeting of the Winnebago County Medical Society featured a discussion of "War Injuries" by Captain George Baumrucker of Hines Hospital, Hines, Illinois, and Dr. Lloyd B. Andrews of Maywood, Illinois.

Milwaukee Academy of Medicine

"Infectious Hepatitis" was the topic of discussion at the March 19 meeting of the Milwaukee Academy of Medicine, the speaker being Dr. M. Herbert Barker of the Northwestern University Medical School Department of Medicine.

Milwaukee Oto-Ophthalmic Society

At its regular meeting held on Tuesday, March 26, in the Milwaukee Athletic Club, the Milwaukee Oto-Ophthalmic Society was presented with the following scientific program: "Allergy of the Eye, Ear, Nose, and Throat: Practical Evaluation and Management of Cases," by Dr. Samuel M. Feinberg, of Northwestern University and Cook County Hospital; with a discussion by *Drs. Theodore L. Squier, F. Herbert Haessler*, and *Frank G. Treskow.*

American Association of Pathologists and Bacteriologists

The Forty-third Annual Meeting of the American Association of Pathologists and Bacteriologists was held in the Department of Pathology at the University of Chicago, March 8 and 9. Included among the many scientific papers read at the meeting was one on the subject of "Boeck's Sarcoid With Severe Purpura" by *Dr. Norbert Enzer* of Milwaukee.

AND ABOUT THE THIRD DISTRICT:

"With a marked concentration of physicians in the Third Councilor District, the *Journal* experiments by assembling all news items pertaining to activities of physicians in Dane, Rock, Green, Columbia, Sauk, Marquette and Adams Counties and presents them together. The *Journal* urges county secretaries to send personal items of interest. Such notices should reach our office by or before the fifteenth of each month before publication."

—EDITOR'S NOTE

SOCIETY PROCEEDINGS

Dane

At its regular monthly meeting, held on Tuesday, March 12, at the Madison Club, the Dane County Medical Society held the following cancer meeting: "A Proposed Program for Cancer Control in Dane County," *Dr. F. E. Mohs;* "Recognition of Malignant Tumors in the Chest," *Dr. A. R. Curreri;* "Diagnosis and Treatment of Cancer of the Prostate," *Dr. J. B. Wear;* and "Malignant Disease in the Abdomen," *Dr. R. T. Cooksey.* A meeting of the Board of Trustees preceded the regular meeting.

Rock

The Rock County Medical Society held its February meeting at the Hotel Hilton in Beloit. The speaker for the evening was Dr. Arthur F. Abt,

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pediatrician from Chicago, who discussed "Endocrine Problems in Children."

University of Wisconsin Medical Society

Meeting in the Service Memorial Institutes Building on Tuesday, March 5, the University of Wisconsin Medical Society heard a presentation of "A Study In Species and Cellular Adaptations and Its Possible Relation to the Genesis of Cancer." Doctor Spencer, who has combined a vast experience with bacteria, protozoa, and viruses with an equally rich knowledge in the cancer field, and has become an outstanding authority on cellular adaptation in relation to cancer, described some of the effects of carcinogenic chemicals on unicellular organisms and mentioned some possible implications of such studies to the genesis of cancer.

Madison Society of Medical Technologists

Addressing the March 6 meeting of the Madison Society of Medical Technologists, *Dr. Helen A. Dickie* spoke on "Tuberculosis." The meeting was held at St. Mary's Hospital.

COUNCILOR DISTRICT NEWS

Dr. Arnold S. Jackson of Madison addressed a meeting of the Southeastern Surgical Congress in Memphis, Tennessee, on Monday, March 11. His subject was "Recent Advances in Surgery." Dr. Alton Ochsner, formerly of Madison, is president of the congress.

—△—

Dr. W. D. Stovall, director of the State Laboratory of Hygiene in Madison, discussed "Wisconsin's Needs for Control of Disease" at a meeting of the Madison Business and Professional Women's Club.

—△—

Dr. H. M. Coon, superintendent of the Wisconsin General Hospital, spoke at a noon luncheon meeting of the Oshkosh Council of Social Agencies at the Athearn Hotel on Wednesday, February 20. He outlined the three main purposes of the hospital as: (1) the teaching hospital for the University Medical School, (2) to promote human service, and (3) to further medical research.

Wisconsin Medical Units Honored

A Homecoming convocation for the 44th Hospital Corps and the 135th Medical Regiment, two Wisconsin medical units, was held in the Memorial Union theater in Madison on Friday, March 1, sponsored by the faculty of the University Medical School and the staff of the Wisconsin General Hospital.

Major General Norman T. Kirk, Surgeon General, speaking on behalf of the Army, praised the two medical units for their outstanding service which had won the "lasting gratitude of all in the War Department."

The Legion of Merit was awarded to *Colonels William J. Bleckwenn* and *Marc J. Musser,* professors of neuropsychiatry at the University, who commanded the 135th Medical Regiment in the Pacific. Colonel Bleckwenn commanded the regiment from the time it went overseas in 1942 until October, 1943; he was succeeded by Colonel Musser.

The 44th General Hospital Corps was commanded by *Colonel Frank L. Weston,* chief of medicine; *Colonel Joseph W. Gale,* chief of surgery; and Ida Bechtold, chief nurse; all are University personnel.

The convocation was presided over by *Dr. Walter J. Meek,* assistant dean of the Medical School; President E. B. Fred spoke to the group for the University; and John J. Callahan, State Superintendent of Public Instruction and University regent, addressed the reception on behalf of the regents.

SOCIETY RECORDS

New Members

Peter V. Hulick, 1020 Market Street, La Crosse.

Victor F. Bruder, Gundersen Clinic, La Crosse.

John A. Carswell, Pinehurst Sanatorium, Janesville.

Horatio V. Crum, Port Washington.

Elmer E. Debus, Mead Wittwer Building, Wisconsin Rapids.

Albert E. Williams, Boyceville.

Leon S. Eagleburger, Stevens Point.

Harold C. Kappus, 604 Seventy-fifth Street, Kenosha.

Frank S. Tuffley, Boscobel.

Elizabeth D. Kane, 523 Howe Street, Green Bay.

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Carl S. Yaillen, 2651 North Forty-fifth Street, Milwaukee.

Marshall L. Weber, 2869 North Fifty-third Street, Milwaukee.

William H. Fritz, Veterans Hospital, Wood.

Digby Gallas, 6911 West Wisconsin Avenue, Milwaukee.

Homer H. Kohler, Sheboygan Clinic, Sheboygan.

Frederick G. Joachim, 1 West Main Street, Madison.

Sarah U. Wykoff, Winnebago State Hospital, Winnebago.

Arthur C. Stirling, 16 South Henry Street, Madison.

Changes in Address

W. A. Joseph, Milwaukee, to Route 1, Box 61, Gulfport, Mississippi.

W. H. Bennett, Kenosha, to 532 Main Street, Racine.

Herman Wolf, Kenosha, to 2821 East Lester Street, Tucson, Arizona.

C. M. Creswell, Kenosha, to 1365 North Hollister Avenue, Pasadena, California.

O. L. Puttler, San Lorenzo, California, to 248 East Main Street, Alhambra, California.

M. F. Regner, Madison, to St. Joseph's Hospital, Marshfield.

Roy B. Larsen, Waunakee, to 1300 University Avenue, Madison.

E. J. Hatleberg, Eau Claire, to Chippewa Falls.

L. M. Cox, Whitehall, to 559 Surf Street, Apartment 5J, Chicago 14, Illinois.

E. C. Glenn, Pittsville, to Wisconsin Rapids.

D. L. Dawson, Rice Lake, to 321 Eau Claire Street, Eau Claire.

A. L. Reinardy, Burlington, to 19 South Main Street, Janesville.

F. J. Hamernik, Waukesha, to St. Luke's Hospital, Chicago, Illinois.

G. F. Burgardt, Milwaukee, to 7361 Harwood Avenue, Wauwatosa.

M. W. Meyer, Green Bay, to Vero Beach, Florida.

P. M. Cornwell, Madison, to 179 Allyn Street, Hartford, Connecticut.

D. W. Melick, Madison, to 1005 Professional Building, Phoenix, Arizona.

S. J. Martin, Viroqua, to St. Francis Hospital, Hartford, Connecticut.

C. J. Moran, Urbana, Illinois, to Burlington.

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DEATHS

Dr. Faye T. Clark, 68, practicing physician in Waupun for over forty-four years, died suddenly Saturday morning, February 23, in his office.

A 1901 graduate of the Chicago Homeopathic College, Doctor Clark opened his practice in Waupun in that year. He was a member of the Dodge County Medical Society, of which he was a former president; the State Medical Society; and the State Board of Medical Examiners, on which he served for eight years. Doctor Clark was mayor of Waupun for three terms, from 1925 to 1931.

The doctor is survived by his wife and two daughters.

Dr. Osville R. Lillie, prominent Milwaukee surgeon, died Thursday, February 21, following a long illness. He was 55 years old.

Doctor Lillie, who had been chief of staff of Milwaukee Hospital since 1941, had served also as clinical professor of surgery at Marquette University Medical School since 1929. He was chief of surgical service at the hospital for many years before becoming chief of staff.

Doctor Lillie graduated from the Marquette University Medical School in 1913 and did postgraduate work in surgery at the University of Pennsylvania. The doctor served as chief medical director for selective service in Wisconsin during World War II; he served overseas on the surgery staff of Base Hospital 22 during the first World War.

Doctor Lillie was a member of the Medical Society of Milwaukee County, the State Medical Society, a fellow in the American College of Surgeons, a member of the Founders Group of the American Board of Surgery, a past president of the Milwaukee Surgical Society and the Milwaukee Academy of Medicine, and had served as Wisconsin surgeon for the Milwaukee and North Western Railroad for twenty-five years.

Survivors include his wife, one daughter, and one son.

Letters to the Editor

THE BLUE BOOK

Dear Sir: "I want to tell you how much I appreciated the State Medical Journal's January issue.

"Your story on the two medical schools in Wisconsin makes it easy for us to answer questions that arise regarding the establishment and developing of both of them.

"We have always made good use of the Blue Book in our admitting office and checking on the importance of medical societies, and I would be pleased to have an additional copy that can be kept in that office for information."

Sincerely yours,
(Signed) H. M. Coon
Superintendent, State of Wisconsin General Hospital

Dear Sir: "It occurred to me that you might be interested to know my reaction to the 1946 Medical Blue Book.

"At the onset let me say that I consider it a mighty fine piece of work. It is my sincere opinion that the current issue deals more comprehensively with its subject matter and is more enlightening than any issue to precede it. While it will serve as a source of general information and guidance for all concerned, its purpose will be very much accentuated among those about to enter practice and those returning from service with the armed forces.

"The efforts which have been expended in producing this volume are appreciated. With me, it will rate as the 'Book of the month.'"

Sincerely yours,
(Signed) John A. Grab
Major, MC

Dear Sir: "On behalf of the members of the Junior Class of the Marquette University School of Medicine, I wish to thank you for the complimentary copies of *The Wisconsin Medical Journal* which you sent us. We deeply appreciate the courtesy extended us."

Very sincerely yours,
(Signed) Frank L. Ziehl
Secretary

Dear Sir: "The Junior class of medical students at the University of Wisconsin Medical School wish to express their thanks and appreciation to the Wisconsin Medical Society for the complimentary copies of the 1946 Medical Blue Book. It is gratifying indeed to know that the Wisconsin Medical Society manifests an active interest in the medical student's welfare."

Respectfully yours,
(Signed) Carl W. Schmidt
Junior Class President

LOAN PACKETS

The Office of the State Medical Society has available loan packets for lay or professional use on the subject of the Wagner–Murray–Dingell Bill and related matters.

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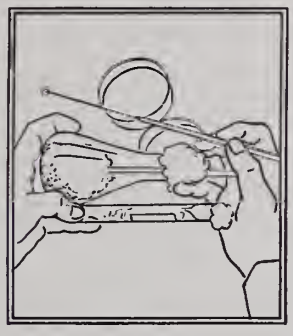

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Mrs. H. J. Heeb, Milwaukee, Vice-president
Mrs. G. J. Hildebrand, Sheboygan, Recording Secretary
Mrs. Leif H. Lokvam, Kenosha, Immediate Past-president
Mrs. R. E. Fitzgerald, Wauwatosa, Parliamentarian
Mrs. J. J. Minahan, Corresponding Secretary, Green Bay
Mrs. N. A. Hill, Madison, Treasurer

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Mrs. P. B. Blanchard, Cedarburg

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Mrs. C. N. Neupert, Madison

MRS. A. H. BARR
Philanthropic

Mrs. Barr is a past chairman of the Press and Publicity Organization, and the Nominating Committee. She has served as president of the Washington-Ozaukee County Auxiliary. A past president of the Port Washington Woman's Club and the Garden Club, she has also served as secretary of the city park board and is a member of the Citizen's Committee. A founder of the Girl Scout Council, she now leads a troop.

Most of our county auxiliaries have a permanent list of philanthropics to which they have contributed in money or service for many years. National charities such as Red Cross and the Women's Field Army for Cancer Control, and local charities such as hospitals, clinics, loan closets, and other public institutions and welfare organizations have been our most popular philanthropics.

Since 1941 our auxiliaries have been giving the greater share of their time, effort, and funds to war-time activities. As the need for these activities gradually disappears we become concerned with the reconversion needs of our own communities. Improved housing and extension of information on hospitalization and sickness insurance plans are two points in the American Medical Association's Constructive Program for Medical Care which need stressing in every community. Many of our philanthropic committees are contributing to health education in cooperation with the Hygeia committees by giving gift subscriptions to schools and clubs. Let me urge you to cooperate now with your public relations committees. Before you adopt any new philanthropic projects, please consider what you can contribute to your public relations committee's new program of health education—educating your own community in favor of *voluntary* medical insurance plans. Let us all work together on this "most urgent need at the present time."*

MRS. G. J. HILDEBRAND
Recording Secretary

Mrs. Hildebrand has been active in the Sheboygan County Auxiliary, having served as president, secretary, and hygeia chairman. During the war she was active in Red Cross work and in civilian defense, and at present works for the War Service committee.

Mrs. Hildebrand is a member of the Women's Clubs of Sheboygan and Kohler.

The duties of the recording secretary consist of recording the minutes of board and general meetings and performing other duties requested by the president. In addition, she must help prepare the agenda before each meeting, file all records except the treasurer's, and turn them over to the archives chairman at the end of the fiscal year.

The recording secretary is also charged with the duty of notifying all members of their election, and in case of a change of treasurer, to certify the new treasurer at the bank.

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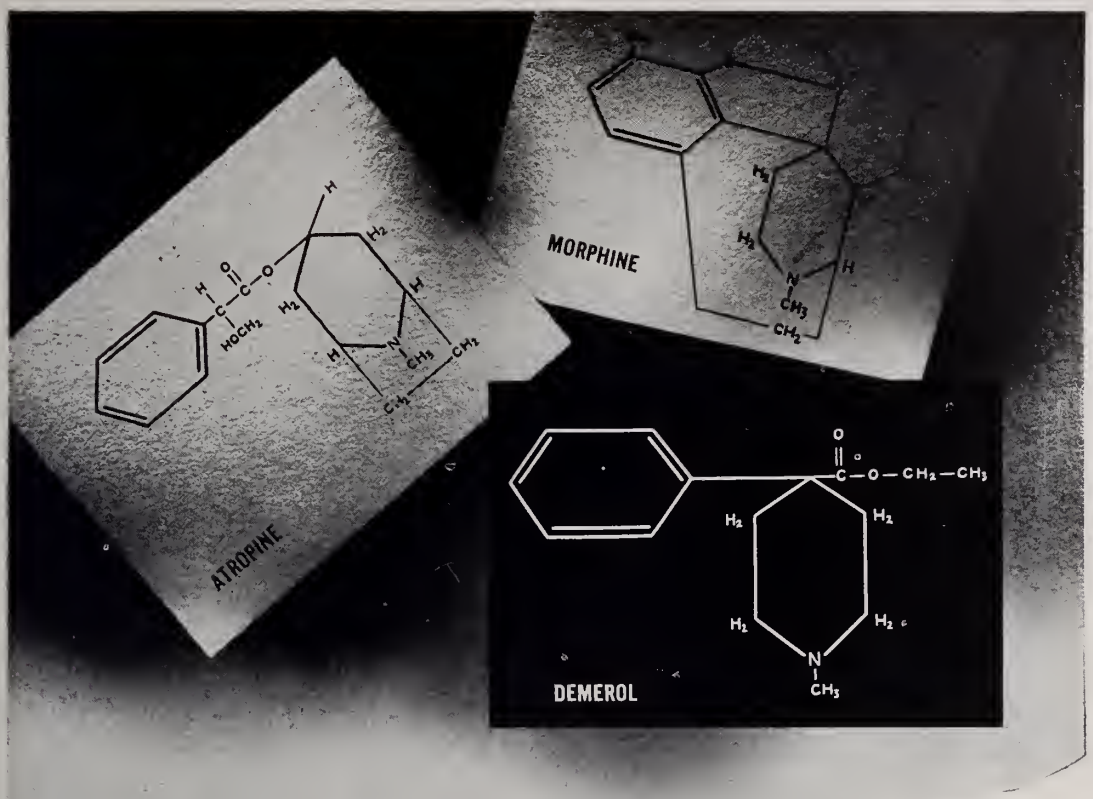
* From Dr. Francis Borzell's resolution, December, 1945, American Medical Association meeting, urging Auxiliary members to inform themselves and the public on medical legislation.



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Report of Midyear Meeting of Board of Directors

THE Woman's Auxiliary to the State Medical Society of Wisconsin met on February 18, 1946, in the English Room of the Hotel Schroeder, Milwaukee, with thirty-six members in attendance. Following the luncheon, the business meeting was called to order by the president, Mrs. Arthur McCarey. Mrs. McCarey extended greetings and expressed her appreciation of the cooperation of members.

There were six past state presidents as honored guests, who were introduced by the president.

The minutes of the Post-convention Board meeting were read and approved.

A letter from the national president to the state president was read, saying that the Y. W. C. A. is planning to support the Wagner–Murray–Dingell Bill at its convention March 2, in Atlantic City. The American Medical Association is asking the Auxiliary to check this movement.

A letter from Doctor Gavin was read, in which he expressed his complete approval of the president's proposed plan for public relations work.

Mrs. McCarey's address, with the urgent plea and challenge to the members of the Woman's Auxiliary, appears on page 448.

The president attended the National Conference in Chicago, December 5 and 6. On December 14 she was guest speaker at the Milwaukee County Auxiliary meeting.

Mrs. James Fox, president-elect, gave her report. She stated that the Woman's Auxiliary is vitally concerned with the health of the community, the state, and the nation. With the crisis of socialized medicine the women must work to promote better understanding and familiarize themselves with the study of health insurance by reading "Sickness and Insurance" by Harry Alvin and "Security Against Sickness" by I. S. Falk.

The chairmen of standing committees' reports were read. Mrs. William Wagner, Archives chairman, reported that she had sent out letters to all county chairmen and urged that clippings be sent to her regularly, and all items of interest from the counties be turned in to be placed in the Archives book.

Mrs. J. S. Huebner, Hygeia chairman, reported 364 subscriptions to Hygeia. Kenosha was in first place with 120 subscriptions, Milwaukee in second place with 63.

Mrs. D. L. Dickerson reported that the chairmen and officers would be given space for a picture, and space for 150 words about their plan for their special committee's work, and 50 words for an article on former activities.

Mrs. Dana B. Dana reported 27 subscriptions to the Bulletin.

Mrs. A. H. Barr reported on a very interesting philanthropic program.

Mrs. James Laird, public relations chairman, attended an informative Public Health meeting in Madison and reported the high lights of that meeting. She will follow the program suggested by the president and will send out soon the public relations study material for county groups to use.

Mrs. Charles Fidler, who served on the national board in 1943 and is chairman of the nominating committee, reported that the slate will be presented at the next meeting. She asked that names of members who are planning to attend the national convention which meets in San Francisco, July 1–6 would send names to her before April 1. The delegates will be selected from that list.

Mrs. William Liefert, convention chairman, reported on the annual meeting plans, which will take place in Milwaukee, Hotel Schroeder, October 6, 7, and 8, 1946.

The reports of the county presidents show that all the women in the various units are vitally concerned with the welfare of their community.

Mrs. Herman Heise, president of Milwaukee County Auxiliary, announced the dates of the second public relations meeting which will be held in Milwaukee in May.

The following members reported for their respective county auxiliaries: Mrs. Frank Cricklair, Brown–Kewauneee–Door; Mrs. W. H. Costello, Dodge; Mrs. A. F. Rufflo, Kenosha; Mrs. M. Siverson, La Crosse; Mrs. H. Heise, Milwaukee; Mrs. F. Huberty, Outagamie; Mrs. Frank Pope, Racine; Mrs. Ira Bemis, Sheboygan; Mrs. Killian Bauer, Washington–Ozaukee; Miss Berthe Voje, Waukesha; Mrs. B. Hughes, Winnebago.

Reports of the officers were presented and approved in the regular way.

There was a lengthy discussion on Health Programs for the Public Relations Committee and also about additional funds for the committee. Mrs. Gramling moved that the program suggested in the President's Message be sponsored by the State Auxiliary. Motion carried.

The president appointed a revisions chairman, Mrs. James Fox of La Crosse. A motion was made and seconded. A revision must be in sixty days in advance of the annual meeting.

All county presidents were asked to have their treasurers send in all dues at once to Mrs. N. A. Hill, Madison, state treasurer. For Wisconsin's representation at the national convention, which will meet in San Francisco in July, it is necessary that all 1945 dues be sent to the national treasurer at this time.

The president requested that all county presidents and chairmen of standing committees send her a brief but comprehensive report, before April 1, so that the information will be included in her report to the national president.

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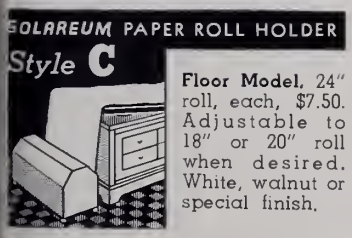

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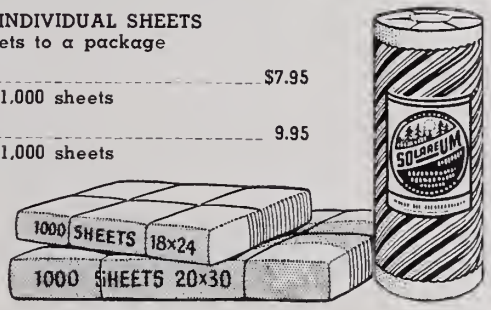

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Mrs. Fidler, chairman of the nominating committee, announced that her slate of proposed nominees would be sent to the president so as to be included in the Call to the Convention.

Mrs. Frank Pope, finance chairman, asked that the chairmen of standing committees and officers send their bills to her before June 1, as audit of the books is made at that time.

The meeting adjourned.

President's Message

MRS. ARTHUR J. McCAREY

Members of the Board and Honored Guests: Our annual meeting, which was held October 20, 1945, in Milwaukee was a meeting of unprecedented importance. It was the first time in the history of our organization that it was necessary to waive a formal meeting of our delegates in convention.

The National Conference, which I attended as Wisconsin's representative, met in Chicago on December 5 and 6, 1945. That was also an occasion to remember. I brought home from that meeting a resolution that was passed by the House of Delegates of the American Medical Association at its session which was held at the same time.

In my message to the Auxiliary members, when I was inducted as president, I mentioned the fact that the only *specific* request that the House of Delegates ever made of the Woman's Auxiliary was in 1931 when members were formally requested to promote the distribution of Hygeia.

In Chicago, December, 1945, the second request was formally made in the following resolution, presented by Dr. Francis Borzell of Pennsylvania:

"Whereas, the object of the Woman's Auxiliary is to aid the American Medical Association in every way requested and,

"Whereas, the most urgent need at the present time is for widespread dissemination of knowledge concerning the hazards of current medical legislation,

"Therefore, be it resolved that the House of Delegates of the American Medical Association request the Woman's Auxiliary to use every avenue possible to bring such information to its members and through them the public."

That was the challenge given to the Woman's Auxiliary by our parent organization. As the Woman's Auxiliary was organized and accordingly acts under the guidance and direction of the Advisory Committee of the American Medical Association, *WE ACCEPT THAT CHALLENGE.*

We have ahead of us, particularly in the next year a fight to the finish on the question of compulsory health insurance. On our side we have the advances and the accumulated knowledge of scientific medicine; arrayed against us are the politicians, the planners, many of whom are unquestionably self-seekers. Our job is to carry to the public the real meaning of compulsory health insurance, in relationship to the public welfare. *In this job there is very definitely a place for the members of the Woman's Auxiliary.*

In the critical year ahead it is essential that the Auxiliary membership keep itself well informed as to the attempts made to change the status of the practice of medicine.

Programs should be arranged to present the doctor's viewpoint and our meetings should be occasionally open to the public. Some groups of women have already endorsed state medicine. We must attempt to give these women *authentic* information regarding this promised medical care, the amount of taxes required to support this socialistic plan, the political bureaucracy it will set up, and so forth.

Our Program Should First:

1. Inform our own membership of the position of the medical profession in regard to medical legislation. This year should be devoted to educational programs on the part of each county Auxiliary, so that we may in turn educate the laity by giving concise and intelligent answers when questioned in regard to it.

a. We should form study groups under the leadership of the public relations chairman. Questions and answers could be prepared by the Advisory Council of the Medical Society. These could be distributed by the county public relations chairmen, and study groups formed so that our members would be ready with definite answers to any questions the laymen might ask them.

b. After intensive study the chairman of such a group should make a report to the membership at large. Details of length of study periods, appointment of chairman, etc., should be under the Public Relations Committee, so that there would be a unified program.

2. A Health Day could also be promoted, where prominent speakers would discuss the issues.

This should be open to the public and invitations sent to various community groups, such as P. T. A.,

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3. Radio Health Education is another important channel through which our Auxiliary should function, and through which reliable health information would be relayed to the public.

We have heard the challenge in a formal request from the American Medical Association. Let us accept that challenge—Let us rally to our doctors' support while they are out defending their noble profession against the socialistic invaders. Let us work together in friendliness to carry on the work of the Auxiliary.

I believe we are able and willing to do this enthusiastically and wholeheartedly.

This is a direct challenge to every doctor's wife.

Auxiliary Proceedings

Brown—Kewaunee—Door

The members of the Woman's Auxiliary met at the home of Mrs. Ernest S. Schmidt, Green Bay, on Wednesday afternoon, January 23. Mrs. John R. Minahan gave a talk on what South Americans think of the United States as reported by Americans who have travelled and lived there. Mmes. I. E. Levitas, Lawrence D. Quigley, and Emile G. Nadeau were in charge of the meeting. During the business meeting unfinished articles for the loan closet were distributed for completion before the next meeting.

Dane

Mrs. Arthur G. Sullivan, Madison, entertained the Woman's Auxiliary at a dessert luncheon on Monday, February 11. After a short business meeting Miss Marvel Ings of Radio Station WIBA spoke on "Women of Wisconsin."

Fond du Lac

Mrs. Leo A. Hoffmann, Campbellsport, President of the Auxiliary, presided at the dinner meeting which was held at the Elks Club in Fond du Lac on Thursday, January 24. One of the important discussions of the evening concerned cancer control and Mmes. J. P. Connell, David Twohig, and J. S. Huebner were appointed to represent the auxiliary at future meetings of the cancer control organization. Mrs. Connell reported on a recent meeting of the state board and Mrs. Twohig on the Yule project of the group. Mrs. Huebner, state Hygeia chairman, conducted a short program in which articles from the magazine were reviewed by Mmes. Stephen A. Theisen, John J. Rehorst, David Twohig, and Harvey R. Sharpe. Mmes. Connell and Twohig were appointed to take charge of plans for the February meeting.

Milwaukee

The regular monthly meeting of the Milwaukee County Auxiliary was held Friday, February 8, with Mrs. William C. Liefert as social chairman. After luncheon at the City Club the members heard a talk by Mrs. Margaret Boulton whose subject was "G. I. Fun in New Guinea." Mrs. Boulton, who is now Y. W. C A secretary in Milwaukee, served with the Red Cross during the war, having spent eighteen months overseas doing recreational work. Following Mrs. Boulton's talk a film showing Red Cross activities in the fields of care and entertainment during the war was shown.

Announcement was made of committee appointments for the Milwaukee County Annual Health Days which will be held on May 2 and 3 at the Milwaukee Auditorium. Mrs. Merle Q. Howard and Mrs. Eben J. Carey are general co-chairmen. Assisting them are: chairman of Inter-organization, Mrs. Milton Klumb; chairman of Lecture Hall, Mrs. E. F. Barta, co-chairmen, Mmes. W. F. Grotjan and Harry Zurheide; Hostesses for lecture hall, Mrs. William C. Liefert, chairman, co-chairmen, Mmes. Urban Schlueter, Roy W. Benton, Emmet Guy; distribution of programs, Mrs. Donald Frawley, chairman, co-chairmen, Mmes. W. F. Lange, George Hoffman, Carroll Partridge; pages for lecture hall, Mrs. John McCabe, chairman, co-chairmen, Mmes. Thornton M. Northey, Norbert Enzer, L. W. Hipke; stage committee for lecture hall, Mrs. R. D. Champney, chairman, co-chairmen, Mmes. Milton Borman, James O. Kelley, Harry R. Foerster; luncheon committee, Mrs. Joseph Adamkiewicz, chairman, co-chairmen, Mmes. Edwin P. Bickler, C. F. McDonald; hostesses for luncheon, Mrs. W. J. Scollard, chairman; co-chairmen, Mmes Harry J. Heeb, Robert G. Washburn; committee for exhibits, Mrs. James C. Sargent, chairman, co-chairmen, Mmes. Francis R. Janney, Carl W. Eberbach, Harry M. Hawkins.

Outagamie

A special meeting of the Auxiliary was called by the president, Mrs. J. J. Huberty, for January 17. Supper was served at the home of Mrs. Ernest N. Krueger, Appleton. Hostesses for the evening were Mmes. William J. Frawley, Edward J. Zeiss, L. B. McBain, Milo E. Swanton, J. J. Young, and F. J. Huberty. Seventeen members were present. Miss Lydia Bouressa, city health nurse, was guest speaker. Her subject was "Health Programs in the Schools." During the business meeting Mrs. James W. Laird, state chairman of the public relations committee, gave a report for that group. The next meeting will be held in March.

Winnebago

Members of the Auxiliary met at the Athearn Hotel, Oshkosh, for a dinner on Thursday, February 7. After a short business meeting the president, Mrs. Byron Hughes, introduced Mr. Paul Yount, director of correction of the state department of public welfare at Madison, who spoke on "Child Delinquency."

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* *Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60

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BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, S. M. I. Building, Madison, Wis.

Pathology of Tropical Diseases. An atlas. By J. E. Ash, Colonel, M. C., U. S. A., Director, Army Institute of Pathology, Army Medical Museum; and Sophie Spitz, M. D., C. S., A. U. S., Pathologist, Army Institute of Pathology, Army Medical Museum. Cloth. Price $8.00. Pp. 350 with 941 illustrations on 257 plates. Philadelphia and London: W. B. Saunders Company, 1945.

The publication of this atlas fills a long-felt need for a text devoted primarily to the pathology of tropical diseases. The subject has been adequately covered in this book. There is a brief description of the clinical aspects of each disease and a somewhat longer, but still concise, discussion of the pathology. The bulk of the book is devoted to the illustrations which are excellent on the whole although a few are so small that it is impossible to recognize any details. All aspects of each disease are portrayed. The illustrations include photographs of the lesion as it is seen in the patient as well as microphotographs of the histopathology and causative agent. Both the clinician and the pathologist will find this volume useful and instructive. E. A. B.

Penicillin and Other Antibiotic Agents. By Wallace E. Herrell, M. D., M. S., F. A. C. P., Assistant Professor of Medicine, the Mayo Foundation, University of Minnesota; Consultant in Medicine, Mayo Clinic, Rochester, Minnesota. Cloth. Price $5. Pp. 348 with 45 illustrations. Philadelphia and London: W. B. Saunders Company, 1945.

In this book Doctor Herrell presents a very comprehensive study of the entire group of known antibiotics. Taking penicillin from its discovery by Sir Alexander Fleming, he goes through all the steps in preparation covering its properties, mode of action including antibacterial activity against various organisms both in vitro and vivo, and toxicity. He describes in detail methods of standardizing and of determining the concentration of penicillin in body fluids. Finally, he discusses the clinical usage, including available preparations, modes of administration, efficacy in various types of infections of the body with the necessary modification in therapy for these different uses. Because of his studies with penicillin, Doctor Herrell has at his command a large amount of personal experience which he uses freely; he does, however, quote the literature and each chapter is complete with an extensive list of references.

The other antibiotic agents, most important of which are Tyrothricin, Streptothricin, and Streptomycin, are considered in relation to their clinical usage, relative toxicity, as well as source and mode of preparation.

This book should be of interest to any clinician using penicillin in practice today. The dosages advised are the minimal, and compared with the schedules offered by other workers, are small. Experience at the present time seems to indicate the necessity of larger dosages in the treatment of many conditions considered. C. J. T.

A Synopsis of Clinical Syphilis. By James Kirby Howles, B. S., M. D., M. M. S., professor of dermatology and syphilology, and director of the department, Louisiana State University School of Medicine; senior visiting physician, Charity Hospital of Louisiana at New Orleans; visiting physician, French Hospital, Mercy Hospital, Hotel Dieu, Southern Baptist Hospital, and Touro Infirmary. Cloth. Price, $6.00. Pp. 671, with 121 text illustrations and 2 color plates. St. Louis: The C. V. Mosby Company, 1943.

This is a small book which effectively and clearly presents the whole field of syphilis. Treatment is thoroughly discussed including massive arsenic therapy, although the author admits that it is still in the experimental stage.

The discussion is divided into three parts: the first nine chapters (Section I) deal with syphilis in general, together with diagnosis and treatment of acquired syphilis; Section II deals with the systems, beginning with the mucous membranes and closing in the twelfth chapter with the endocrine glands; Section III deals with syphilis in pregnancy, congenital syphilis, and the public health aspect.

The index is well done and there is an excellent list of references at the end of the book.

The synopsis can be recommended to the general practitioner. G. A. C.

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Clinical Roentgenology of the Digestive Tract. By Maurice Feldman, M. D., Assistant Professor of Gastroenterology, University of Maryland, Assistant in Gastroenterology, Mercy Hospital, and Consulting Roentgenologist, Sinai Hospital. Second edition. Cloth. Price $7.00. Pp. 749 with numerous photographs and drawings. Baltimore: The Williams & Wilkins Company, 1945.

The first edition of this book was published in 1938; the present edition has been revised and rewritten to bring the material up to date. There are twenty chapters, each given over to a separate division of the gastro-intestinal tract and abdomen. Thus each organ and the disease involving it receive separate consideration. This is desirable in a book intended as a reference work. Considerable attention is paid to the clinical aspects of disease. Descriptions of roentgen change are, on the whole, adequate but in many instances could have been enhanced by better organization of the text, elimination of contradictory statements from the literature, a larger number of illustrations, and references in the textual matter to the corresponding illustration under discussion. Roentgen technic is given scant attention except in paragraphs scattered throughout the text. It would have been better to have devoted a section to this very important phase especially since the book is intended for clinicians, students, and general practitioners, among others. Quotations from the literature are numerous and each section is followed by a satisfactory list of references. The coverage is very complete and the present volume has been brought up to date. The book has value as a reference work for much of the worth-while literature on gastro-intestinal roentgenology and because of the wide variety of subjects discussed including many little known entities. L. W. P.

Elimination Diets and The Patient's Allergies. By Albert H. Rowe, M. D., lecturer in medicine, University of California Medical School, San Francisco, California; consultant in allergic diseases, Alameda County Hospital, Oakland, California. Ed. 2. Cloth. Price $3.50. Pp. 256. Philadelphia: Lea & Febiger, 1944.

The edition contains essentially the same material included in the 1941 edition. The elimination diets accompanied by detailed recipes make the problem of allergic dietary management more simple for the patient and the doctor. The present edition contains additional recipes which conform to war-time restrictions and limitations. Short mention is made of other recent developments including oral pollen desensitization, evaluation of desensitization in general, physical allergy, intrinsic allergy, allergic fever, schedule of histamine therapy. The author has also revised material in the chapters under Cause and Diagnosis, the cause, diagnosis and treatment of allergy in general. Those familiar with the previous edition will welcome this war-time volume as concise and practical. H. D.

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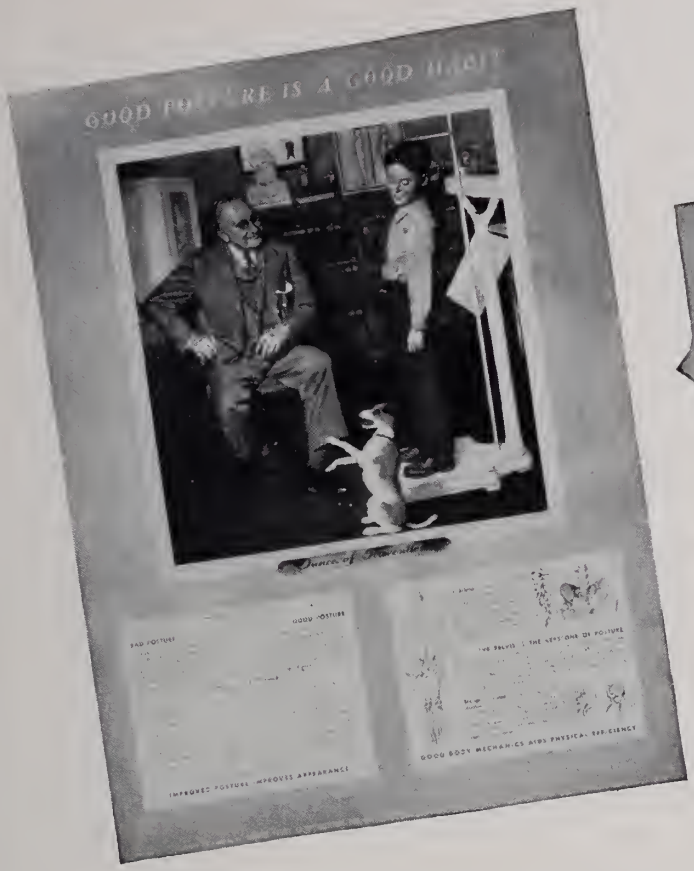

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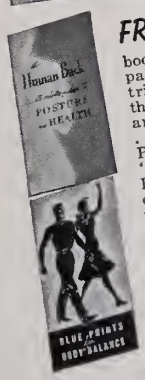

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Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1943. With the comments that have appeared in the journal. Cloth. Pp. 147. Chicago: American Medical Association, 1944.

This booklet presents the assembly of the reports of the Council on Pharmacy and Chemistry for the year 1943 and is in a very useful and convenient form. Such discussions as that by Boyer on Aminophylline may not meet with complete accord by all cardiologists, yet constitutes a thought-provoking stimulus. The article on Vitamin D and rheumatoid arthritis is timely and properly critical. On the metric system and its adoption in medicine one finds clear and most convincing arguments. Some thirty other topics are more or less similarly presented. A. L. T.

Collected Papers of the Mayo Clinic and The Mayo Foundation. Edited by Richard M. Hewitt, B. A., M. A., M. D.; A. B. Nevling, M. D.; John R. Miner, B. A., Sc. D.; James R. Eckman, A. B.; and M. Katharine Smith, B. A. Volume XXXIV–1942. Cloth. Price, $11. Pp. 999, with 176 illustrations. Philadelphia: W. B. Saunders Company, 1943.

The papers of this volume cover principally the year 1942 and embrace a wide range of subjects which might interest the general practitioner. There are 513 articles, many from the "Proceedings of the Staff Meetings of the Mayo Clinic." The first section covers "Recent Advances in Chemotherapy" and will be of especial interest. Most of the papers in this section naturally have to do with the sulfonamides. Other general headings are, "Alimentary Tract," "Genitourinary Organs," "Ductless Glands," "Blood and Circulatory Organs," "Skin and Syphilis," "Head, Trunk and Extremities," "Chest," "Brain, Spinal Cord and Nerves," "Radiology and Physical Medicine," "Anesthesia and Gas Therapy," and "Miscellaneous." There is much of interest in this book for any reader although, obviously, with such diversification, not all portions of the volume will be equally valuable to everyone. The standard of previous volumes is maintained. O. O. M.

Medical Gynecology. By James C. Janney, M. D., F. A. C. S., Assistant Professor of Gynecology, Boston University School of Medicine, Boston, Massachusetts. Cloth. Price $5.00. Pp. 389 with 97 illustrations. Philadelphia and London: W. B. Saunders Company, 1945.

This compact volume sets out to describe the subject of minor clinical practice. It is a better book for the student than for the practitioner. Much space is given to history taking and pelvic examination. Trichomonas vaginalis is inadequately discussed. Monilia is not mentioned. The treatment of gonorrheal infection is not up to date. The use of the sulfonamides is indefinite and the comments on penicillin are brief and inadequate.

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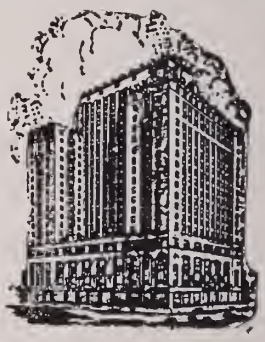

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TREATMENT OF UNDULANT FEVER WITH STREPTOMYCIN
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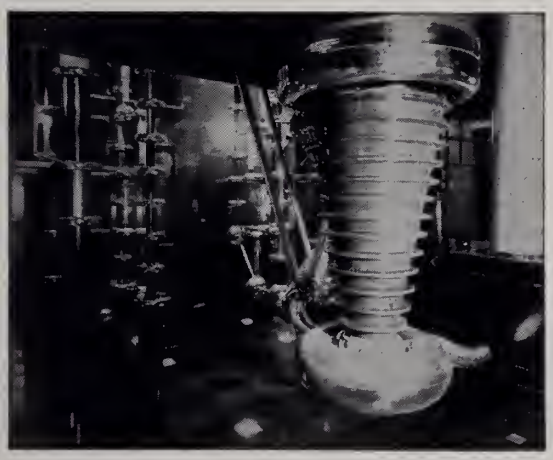

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1 *Stare, F. J., and Thorn, G. W.: Protein Nutrition in Problems of Medical Interest, J.A.M.A. 127:1120 (April 28) 1945.*

2 *Stare, F. J., and Davidson, C. S.: Protein: Its Role in Human Nutrition; Introduction, J.A.M.A. 127:985 (April 14) 1945.*

3 *Anderson, G. K.: The Importance of Protein in Diet Therapy, J.Am.Dietet.A. 21:436 (July-August) 1945.*

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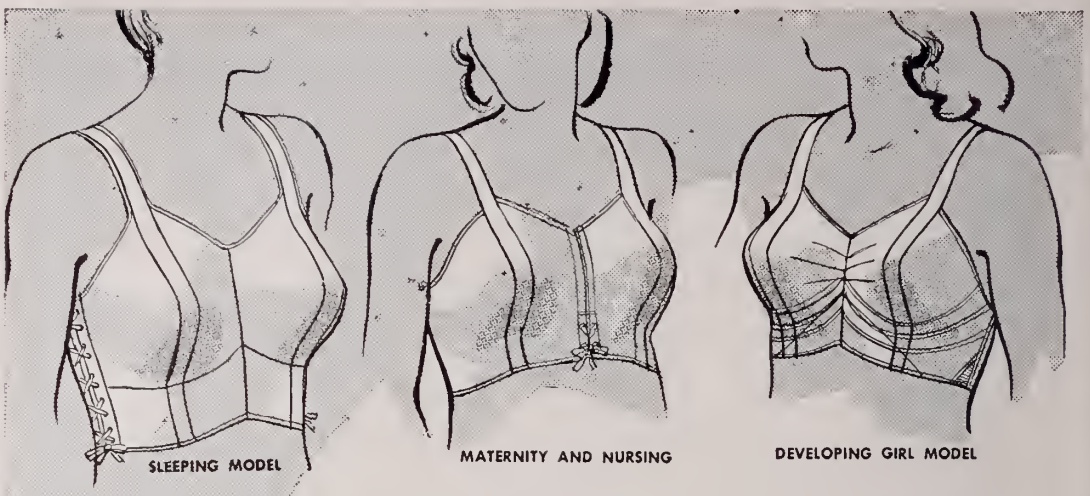

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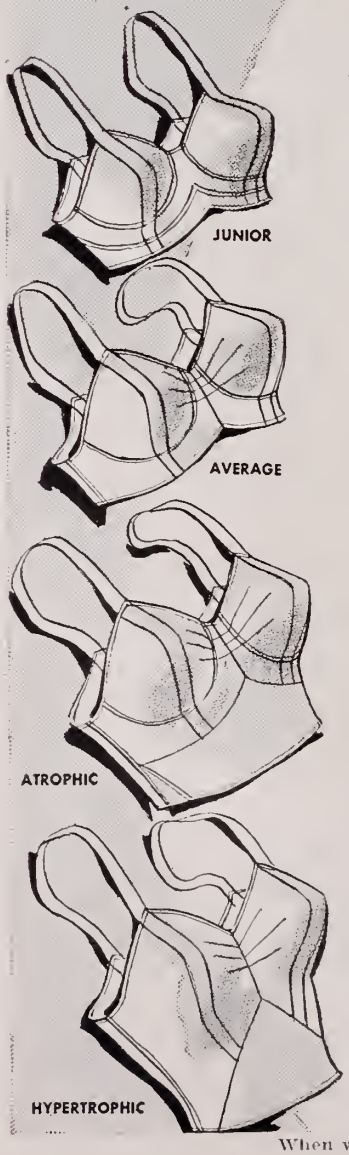

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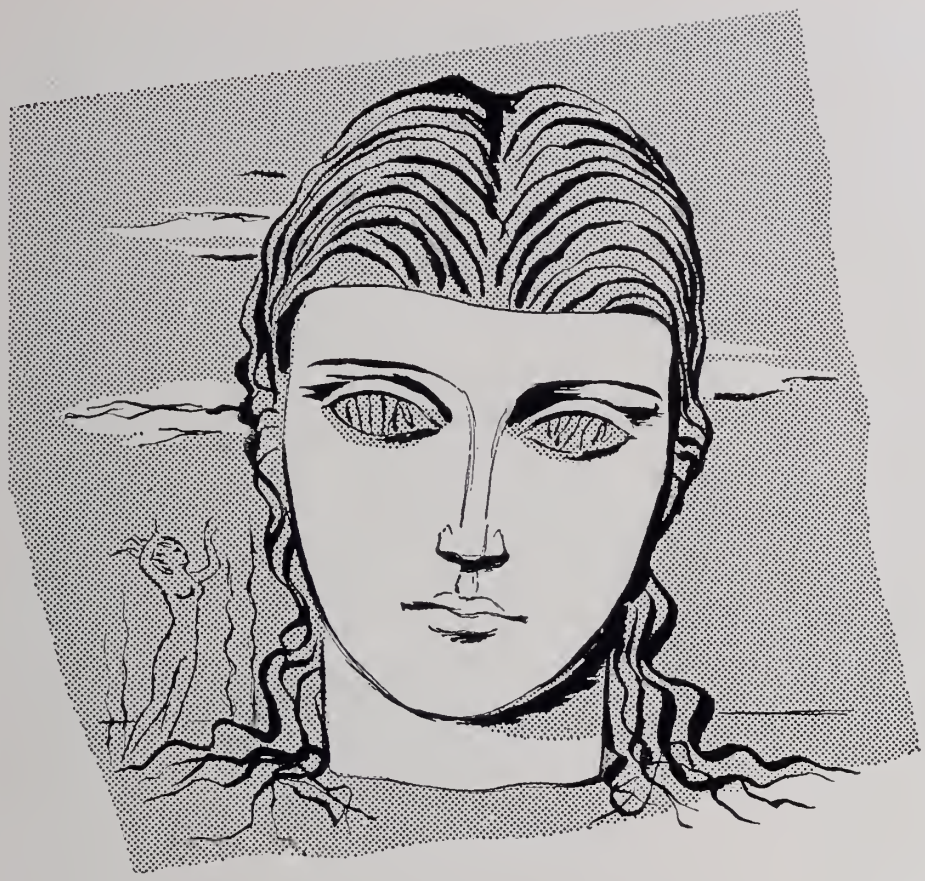

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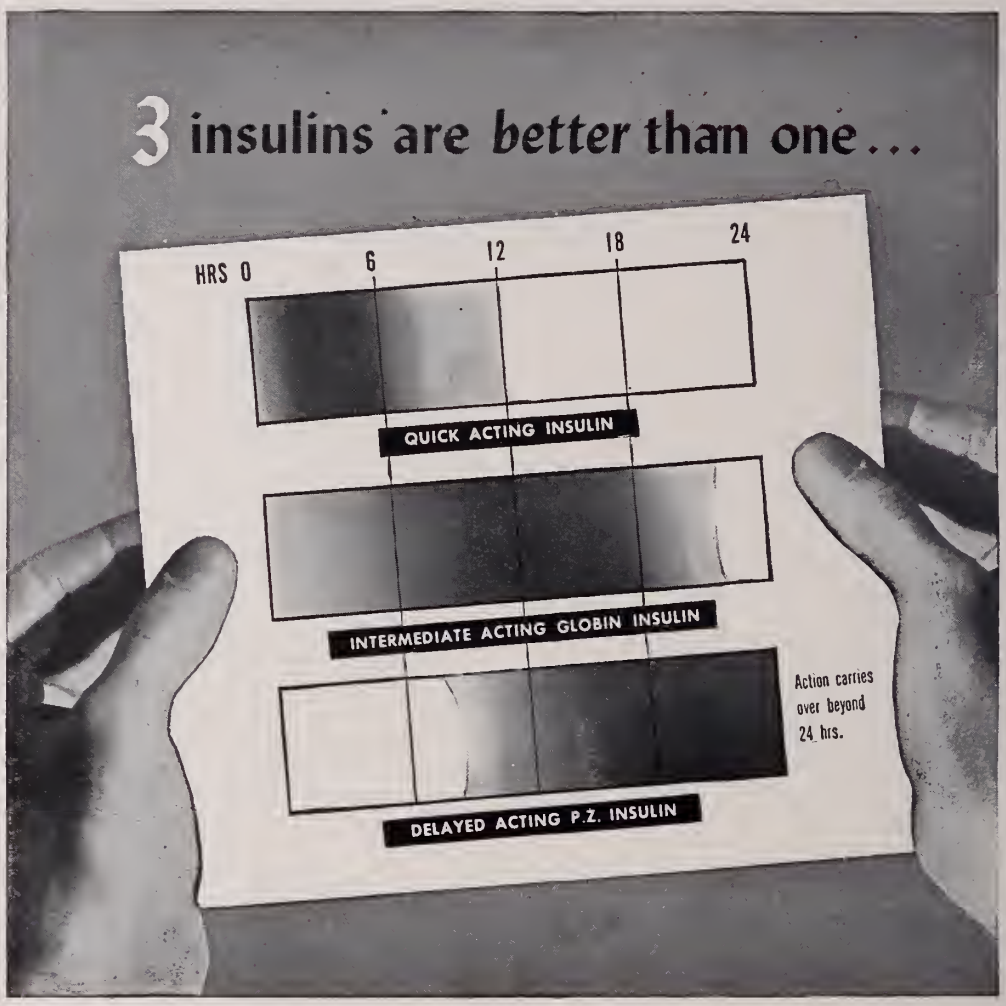

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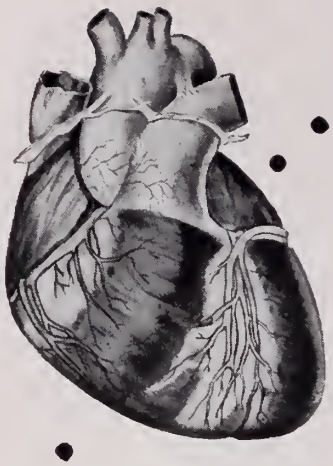

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*Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154
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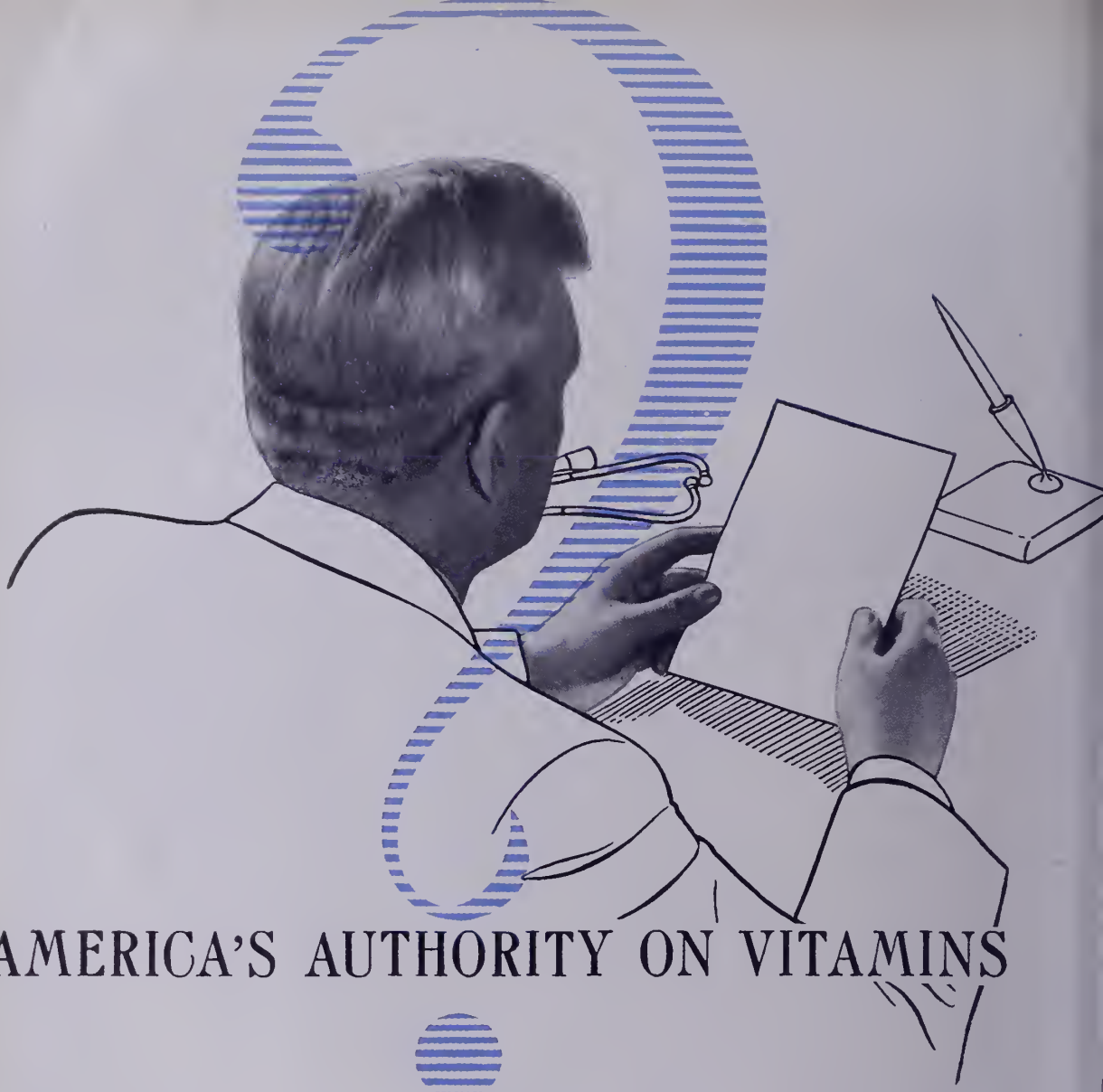

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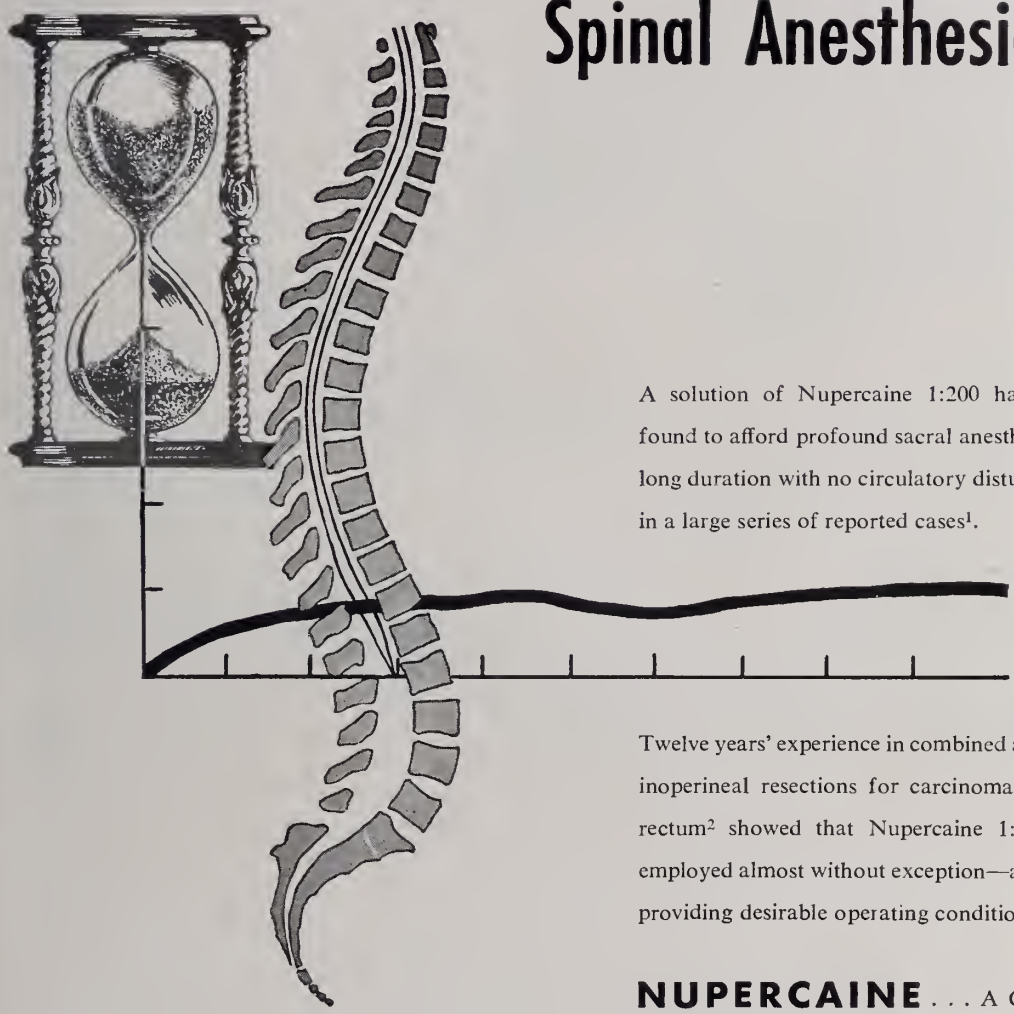

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[1] Clement, F. W. & Elder, C. K.: Anesth. 4:516, 1943
[2] Coller, F. A. & Ransom, H. K.: Surg. Gynec. & Obst., 78:304, 1944

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Treatment of Allergic Conditions With Pyribenzamine and Benadryl*

By STEPHAN EPSTEIN, M. D.
Marshfield

STEPHAN EPSTEIN

Doctor Epstein, a graduate from the University of Erlangen in Germany in 1923, was formerly assistant at the University Skin Clinic in Breslau, and later its acting physician-in-charge. He is now dermatologist and allergist at the Marshfield Clinic, a member of the extramural teaching staff of the University of Wisconsin Medical School, and Lecturer in Dermatology at the University of Minnesota Medical School.

MANAGEMENT of the allergic patient frequently remains rather unsatisfactory, in spite of the good results obtained in many instances by proper allergic management and symptomatic control. Therefore every new method appears welcome that promises added relief for the allergic sufferer. In recent years antihistaminic drugs have been introduced that afford control of symptoms in some allergic conditions, notably urticaria, hay fever, asthma, and allergic dermatitis. In this country, two drugs have received special attention, benadryl,** and pyribenzamine.*** The following is a report about these drugs based on the literature and my own limited experience with them.

Background of Antihistaminic Therapy

The use of antihistaminic substances in allergic conditions is based on the assumption that histamine plays a role in their causation. In 1911 Dale and Laidlow presented the histamine theory of the anaphylactic shock; later Lewis claimed that a histamine-like substance, his so-called "H" substance, was responsible for the production of the urticarial wheal. In recent years further evidence has been accumulated to support the histamine theory of allergic manifestations. This subject is still under discussion, but we may safely assume that release of histamine or a histamine-like substance is a factor in certain allergic conditions. Somewhat simplified, the theory may be presented as follows. As an example I shall use an individual that has become allergic to ragweed pollen and presents the symptoms of hay fever. The ragweed in this case is called the allergen or antigen.

The Allergic Chain Reaction****

1. The individual becomes sensitized to the antigen, in this instance the ragweed pollens.

2. The sensitized individual produces specific antibodies to this antigen (ragweed); fixed antibodies settle in the mucous membranes of the nose and the conjunctiva. These tissues are the so-called "shock organ" and determine the localization of the clinical manifestations, in this instance, of hay fever.

---

* Paper read before the joint meeting of the Wood County and Clark County Medical Societies, Marshfield, February 7, 1946.

** Benadryl supplied through the courtesy of the Department of Clinical Investigation of Parke, Davis and Company.

*** Pyribenzamine supplied through the courtesy of the Research Division of Ciba Pharmaceutical Products, Inc.

**** This presentation is schematic and oversimplified.

3. Upon renewed exposure to the antigen (the ragweed pollen) an antigen-antibody reaction occurs at the shock organ.

4. The antigen-antibody reaction leads to release of histamine or a histamine-like substance.

5. This histamine or histamine-like substance causes inflammation of the cells of the shock organs, conjunctiva, and nasal mucosa, and thus produces the clinical symptoms of hay fever.

The Treatment of Allergy

The scheme presented above also indicates the various avenues of therapeutic approach to allergic conditions in man. So far, the most common methods are designed to prevent the antigen-antibody reaction. This can be accomplished by avoidance or elimination of the antigen. The patient suffering from ragweed hay fever may move to a ragweed-free territory during the fall; or the individual afflicted with a food allergy can eliminate this particular food from his diet. Where such a way is impossible or impractical, an attempt may be made to neutralize the other partner of the antigen-antibody reaction, namely the antibody. This is accomplished by the various methods of desensitization. But there are many instances where these methods cannot be used or where they have failed; in these instances, often all that one can do is to treat the clinical symptoms.

Recently further attempts were made to break this allergic chain reaction. If one could not prevent the antigen-antibody reaction, one might at least break the chain before the histamine or the histamine-like substance would cause the damage. That led to the use of antihistaminic substances.

The first one used was "histaminase," an enzyme that destroys or counteracts histamine. This enzyme had been widely used a few years ago under its trade name torantil. Unfortunately, it has not lived up to expectations, although it seems useful in occasional instances, especially cases of food allergy.

The next steps were attempts to desensitize to histamine. If histamine were the real culprit that produced the tissue damage regardless as to what allergen might have been the original reactor, why not desensitize to this common denominator of allergic reactions? The observation of increased sensitivity to histamine observed in some cases was a further stimulus for this method. To begin with, histamine was used. When it became clear that histamine alone would not produce antihistaminic antibodies, histamine was coupled to a protein to acquire antigenic properties. A so-called conjugate antigen was produced which is marketed under the trade name hapamin. Recent investigation seems to indicate that even this conjugate antigen is not capable of producing antibodies to histamine, but this is still a matter of controversy. Be that as it may, histamine and hapamin therapy also has not lived up to the original expectations and claims. There is wide disagreement among the observers. At the present time, we are at a low ebb of professional opinion in regard to histamine and hapamin therapy. Still these methods seem to have merit in some cases.

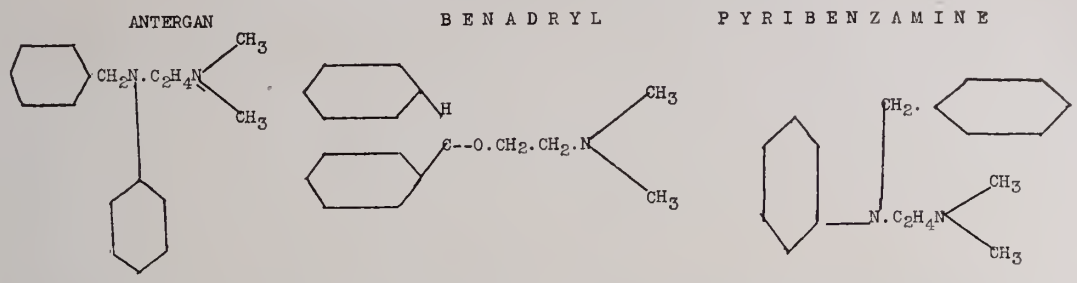
TREATMENT WITH ANTIHISTAMINIC DRUGS*

Pyribenzamine and Benadryl

In 1937 and 1939 Bovet and Staub, at the Pasteur Institute of Paris, detected the antihistaminic activity of certain derivatives of amino-ethanol and ethylenediamine.[4a] As these drugs were too toxic for clinical usefulness, less loxic compounds later were detected in the same group. One of them is N-dimethylaminoethyl-N-benzylaniline. This drug has been marketed in Europe under the trade name of "Antergan," and proved clinically effective. In this country these chemicals were further investigated by two pharmaceutic houses. Parke, Davis and Company developed a drug which is called "Benadryl." The chemical name for this compound is Beta-dimethylaminoethyl benzhydryl ether hydrochloride. Ciba Pharmaceutical Products, Inc., introduced another antihistaminic drug which is called "Pyribenzamine." The chemical name is N^1-pyridyl-N^1-benzyl-N-dimethyl-ethylendiamine mono hydrochlor-

* This chapter is based on the reports of Arbesman, Koepf, and Miller,[7f] Code,[8f] Feinberg,[7a] R. L. Mayer.[4a] These papers contain pertinent bibliographies.

TABLE 1.—STRUCTURAL FORMULAS OF ANTIHISTAMINIC DRUGS



ide; the structural formulas of these antihistaminic drugs are presented in Table 1. Benadryl and pyribenzamine are both white crystalline powders, soluble in water. These two drugs have a remarkable similarity in regard to their physiologic and antiallergic action so that one may discuss them together. In animals both drugs have a very low toxicity when given orally, but appear rather toxic when injected intravenously. The lethal dose (L.D.–50) is 12 to 50 times smaller for the intravenous as compared with the oral route, as seen in Table 2:

TABLE 2.—TOXICITY OF PYRIBENZAMINE AND BENADRYL*

Animal	Route	Pyribenzamine Lethal Dose (L.D.–50) mg./kg.	Benadryl Lethal Dose (L.D.–50) mg./kg.
Rats	Oral	535 Female	545 Albino
	Intravenous	10–11 Rats	45 Rats
Rabbits	Oral	400–500	
	Intravenous	10–11	10–11

* Information supplied by Parke, Davis and Company and by Ciba.

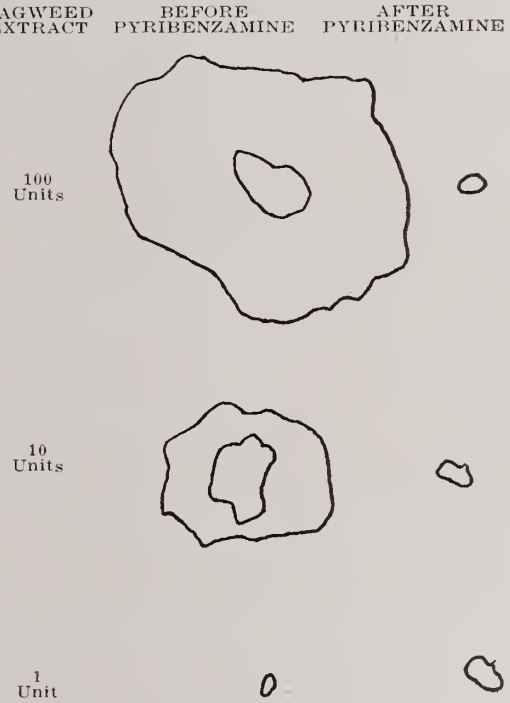
Both pyribenzamine and benadryl prevent the typical effects of histamine, and also counteract the anaphylactic shock of sensitized guinea pigs[2, 4b] and in dogs.[9]

TABLE 3.—PROTECTION AGAINST ANAPHYLACTIC SHOCK IN GUINEA PIGS WITH PYRIBENZAMINE[(1b)]

Treatment	No. of Animals	Mortality
Untreated	2	100%
Pyribenzamine		
0.1 mg./kg.	2	50%
0.5 mg./kg.	3	33%
1.0 mg./kg.	5	No mortality

The effectiveness of pyribenzamine as well as benadryl has furthermore been demonstrated by reports of inhibition of both the histamine wheal and the allergic wheal[7b, 7f] following intradermal injection of the antigen.

FIGURE I.—EFFECT OF PYRIBENZAMINE ON ALLERGIC WHEALS*



However, like histaminase, both drugs are not absolutely specific antihistaminics. Histaminase is an enzyme that detoxifies not only histamine but also a whole series of toxic diamines.[8f] Pyribenzamine and benadryl are highly specific against histamine, but both are also mildly effective against acetylcholine[9] and probably possess additional pharmacologic qualities as evidenced by

* From Arbesman, Koepf and Miller[(7f)]: "Pyribenzamine had very little effect on the results of strongly positive skin reactions. Only the weakly positive reactions (1+ to 2+) were affected."[(7f)]

their sedative effect. Therefore, the fact that an allergic condition is relieved by pyribenzamine or benadryl is not absolute proof that the condition was caused by the release of histamine. I have seen, for instance, prompt relief in an intractable case of cholinergic urticaria, a condition which is considered caused by sensitivity to acetylcholine.

CLINICAL EFFICACY OF BENADRYL AND PYRIBENZAMINE

Clinical trials have borne out the anti-allergic ability of pyribenzamine and benadryl that was indicated by the experimental results. To be sure, these drugs exert only a symptomatic effect, but so far the results are very encouraging as can be seen from the Tables 4, 5, 6, and 7. The results are sometimes dramatic, especially in acute urticaria and drug eruptions.[3, 8a]

TABLE 4.—URTICARIA

Drug	No. of Cases	Improved		Failure	
		Total	%	Total	%
Pyribenzamine					
Acute Urticaria					
From Literature (7g)	15	14	93	1	7
Our Cases	8	8		0	
Chronic Urticaria					
From Literature (7g)	44	33	75	11	25
Our Cases	6	5		1	
Benadryl					
Acute Urticaria					
From Literature (1, 3, 6, 7b, 8a, 8b)	43	40	93	3	7
Our Cases	8	8		0	
Chronic Urticaria					
From Literature (1, 3, 6, 7b, 7c, 7d,, 7e,8b)	138	111	80	27	20
Our Cases	2	2		0	

Urticaria

Acute urticaria and urticarial drug eruptions respond to pyribenzamine and benadryl better than any other allergic condition. The itching is usually relieved first; then the swelling and the hives disappear, at times extremely rapidly. In some instances the relief is complete; other cases are only improved. In acute cases that normally last only a few days, this amounts practically to a cure. In chronic urticaria most cases derive symptomatic improvement; as a rule, the urticaria recurs when the drug is withdrawn and again brought under control when the medication is resumed. In some cases the effect of the drug seems to wear off under these circumstances. Table 4 demonstrates the excellent results.

Hay Fever and Allergic Rhinitis

These conditions also respond very well to benadryl and pyribenzamine as presented in Table 5:

TABLE 5.—HAY FEVER, EXTRINSIC AND INTRINSIC ALLERGIC RHINITIS*

Drug	No. of Cases	Improved		Failure	
		Total	%	Total	%
Pyribenzamine From Literature (7g)	200	152	76	48	24
Benadryl From Literature (7b, 7c, 7d, 7e, 8a, 8c, 8d, 8e)	303	197	65	106	35
Our Cases**					
Pyribenzamine and Benadryl (Only non-seasonal allergic rhinitis)	18	12		6	

* The figures are not fully comparable, as they represent averages from different conditions. The results in extrinsic and intrinsic rhinitis differ widely; the extremes were 85% improvement in pollen hay fever (7g) and only 10% in perennial vasomotor rhinitis (7b).

** Observed by Drs. Lyman A. Copps, G. L. McCormick, and Stephan Epstein.

Apparently the pollen sensitive cases are benefited most.[7d, 7e, 7g] The effect is not quite so good in extrinsic allergic rhinitis, that is in cases with allergy to dusts or foods. The results are still poorer in the so-called intrinsic allergic rhinitis[7g] where external allergens cannot be demonstrated.

Asthma

The results of treatment with pyribenzamine and benadryl in bronchial asthma so far are somewhat disappointing as brought out by Table 6.

TABLE 6.—ASTHMA

Drug	No. of Cases	Improved		Failure	
		Total	%	Total	%
Pyribenzamine From Literature (7g)	54	23	42	31	58
Benadryl From Literature (7b, 7c, 7d, 7e, 8a, 8c, 8e	212	105	50	107	50
Our Cases* (Benadryl and Pyribenzamine)	11	5		6	

* Observed by Drs. Robert S. Baldwin and Stephan Epstein.

Atopic Dermatitis (Allergic Eczema)

The evaluation of the antihistaminic drugs in atopic dermatitis (allergic eczema) is very difficult. Opinions on this subject are divided. I have been especially impressed with the relief of the pruritus that accompanies atopic dermatitis. I have not seen objective changes in long-standing atopic dermatitis, but acute exacerbations have been definitely checked in some cases. In my experience, pyribenzamine seemed more effective, but the number of cases treated does not permit any definite conclusions.

TABLE 7.—ATOPIC DERMATITIS

Drug	No. of Cases	Pruritus Relieved	Failure
Pyribenzamine	7	7	
Benadryl	11	9	2
Literature: Benadryl (7b, 7e)	19	13	6

The value of benadryl and pyribenzamine in other forms of dermatitis and eczema is not definitely established as yet. I have been uniformly disappointed in cases of contact dermatitis and infectious eczemas. (See Table 8) Encouraging results have been reported in pruritus vulvae.[3, 7b] I have noted very good results in four out of six cases of anal pruritus. The drug seems also of value in erythema multiforme.[1, 3, 5]

TABLE 8.—RESULTS IN OTHER DERMATOLOGIC CONDITIONS TREATED WITH BENADRYL AND PYRIBENZAMINE

Diagnosis	No. of Cases	Improved	Failure
1. Proven Contact Dermatitis	4		4
2. Infectious Eczematoid Dermatitis	3		3
3. Pruritus Ani and Vulvae	7	4	3
4. Drug Eruptions	3	2	1

There are a number of other conditions for which benadryl or pyribenzamine have been suggested or used. The few available reports in regard to migraine, Meniere's disease are disappointing, but occasionally a case has been helped. So far there is not enough experience to come to definite conclusions.

The tables presented indicate that the results obtained with either pyribenzamine or benadryl are about the same. In my cases, too, I have not seen any marked difference between the two drugs, although some of my patients did better with benadryl and others with pyribenzamine.

Anti-histaminic drugs also have been useful in preventing allergic reactions from medications.[7g] We have made a similar observation in a patient who reacted with a severe urticaria to all forms of insulin. Pyribenzamine given simultaneously with the insulin has suppressed her urticaria completely or nearly so. It seems preferable[7g] to give the pyribenzamine forty-five minutes before the contemplated injection.

DOSAGE AND ADMINISTRATION

The dosage recommended for both drugs is identical. Oral administration only is recommended at present. The average dose is 50 mg. three or four times a day. If the symptoms are controlled, the dose is reduced to one-half or less; if not, the dose may be doubled and 100 mg. may be given three or four times daily.

Both drugs are rather well tolerated. However, a number of side effects have been reported, chiefly sleepiness or drowsiness and

dizziness. Less frequently dryness of the mouth, nausea, and diarrhea have occurred. With the normal dosage of 50 mg. three or four times a day, these side effects have been very mild in my experience and never demanded a discontinution of the therapy. In most instances the patients did not even complain spontaneously. This holds true for both benadryl and pyribenzamine. However, my material would indicate that these side effects were less frequent with pyribenzamine.

FAILURES

There is a great variation of the therapeutic effect of these antihistaminic substances; for instance, they are very effective in hay fever and rather poor in asthma. The question about the failure of these drugs in some cases cannot be answered fully at present, but some hints seem possible. Actually urticaria, rhinitis, and asthma are not diseases but symptoms. Not all cases classified under these names are allergic in origin. But even among allergic urticaria, allergic rhinitis, and allergic asthma there may exist great differences in the type of sensitivity. We may distinguish three main forms of allergic sensitization; the anaphylactic (or atopic) type, the tuberculin type, and the "eczematous" contact type sensitivity.

Their distinction is presented in Table 9.

If we study urticaria, hay fever, allergic rhinitis, and asthma from this angle, we find that most cases of hay fever are based on anaphylactic sensitivity; that probably applies also to acute urticaria. Even in these cases infectious sensitivity may co-exist. In allergic rhinitis of the perennial type and especially in asthma, bacterial sensitivity plays an increasing role. This holds true not only for the so-called intrinsic asthma of the middle-aged and older person, but also for all other forms of asthma. The frequent occurrence of bacterial asthma or asthma bronchitis in children and its association with extrinsic asthma at this age is well known.

Therefore it seems logical that we should expect help from antihistaminic drugs only in the anaphylactic form of sensitivity because here release of histamine or a histamine-like substance is an important factor. It is different with the tuberculin type of reaction. So far I know of no evidence that

TABLE 9.—COMPARISON OF DIFFERENT TYPES OF SKIN HYPERSENSITIVITY

Type of reaction:	Anaphylactic or atopic reaction	Tuberculin type or microbic type reaction	Contact type or "eczematous" reaction
Clinical lesion:	Wheal	Papular lesion	"Eczematous" dermatitis
Pathologic characteristic:	Urticarial	Inflammatory	Inflammatory
Time of appearance of of reaction:	"Immediate" (within a few minutes)	"Delayed" (after 8 to 48 hours)	"Delayed" (after 8 to 48 hours)
Shock Organ:	Vascular tissue	Cutis	Epidermis
Antibodies:	Free antibodies in serum	Only fixed antibodies	Only fixed antibodies
Release of histamine or histamine-like substance:	+	Not demonstrated	Not demonstrated
Result of invitro antigen-antibody reaction:	No damage to tissue	Damage to cells	Damage to cells
Relation of site of test to intensity of reaction:	No difference	Reaction stronger the closer to primary focus	Reaction stronger the closer to primary focus
Eosinophilia	Usually +	0 or +	0 or +
Heredity	+	?	?

histamine plays a role in its mechanism.* It appears understandable then that we could not expect much help from antihistaminic drugs in allergic conditions based on tuberculin-type sensitivity; this may help—in part—to explain the limitations of benadryl and pyribenzamine in cases of allergic rhinitis and asthma connected with bacterial allergy.

The favorable effect of pyribenzamine and benadryl on the pruritus of atopic dermatitis as contrasted with the failure of these drugs in contact dermatitis[7g] and other eczemas (Table 8) may find a similar explanation. Contact dermatitis is based on a form of skin sensitivity which is very similar, if not identical, to the tuberculin type sensitivity. Table 8 demonstrates that the principal difference between tuberculin type sensitivity and "eczematous" contact type sensitivity appears to be the shock organ. The shock organ in tuberculin type sensitivity is the cutis, in eczematous contact type dermatitis mainly the epidermis, although in clinical contact dermatitis the cutis may be also involved.

Conclusions and Summary

1. The new antihistaminic drugs, pyribenzamine and benadryl, are very efficacious in the symptomatic treatment of urticaria and hay fever, and to a lesser extent in perennial rhinitis, asthma, atopic dermatitis (allergic eczema), and other forms of allergy. Although benadryl and pyribenzamine are somewhat different chemically, there does not seem to be much difference in their clinical efficacy. Both drugs afford the same percentage of relief in various allergic conditions; for instance, about 95 per cent in acute urticaria, 80 per cent in chronic urticaria, 80 per cent in hay fever and extrinsic allergic rhinitis, and about 40 to 50 per cent in bronchial asthma. The pruritus of atopic dermatitis seems relieved more or less in about 60 to 90 per cent of the treated cases.

2. Benadryl as well as pyribenzamine exert only a symptomatic effect. That limits their usefulness. However, symptomatic relief may equal a clinical cure in self-limited allergies such as attacks of acute urticaria, drug eruptions, or hay fever. In chronic allergies the symptoms usually reappear when the drug is withdrawn. These drugs may also help during the allergic investigation. The patient whose symptoms can be largely controlled will be better able and more prone to go through the trying time of a prolonged allergic investigation.

3. Pyribenzamine and benadryl are of low toxicity when given orally, and are well tolerated. The unwanted side effects such as sleepines and dizziness are usually mild with normal dosage. These drugs do not possess the exciting and blood pressure raising qualities of ephedrine. In general they have a sedative effect, although occasionally a patient may become agitated.

4. From the foregoing it appears that benadryl and pyribenzamine are useful adjuncts in the therapy of allergic conditions. Their full value has not yet been determined. We should keep in mind the natural limitations of these drugs and beware of unwarranted over-optimism.

* Protein antigens such as pollens or dusts or foods usually produce the anaphylactic type of reaction, whereas bacterial and other microbic antigens preferably induce the tuberculin type of sensitivity. Exceptions to this rule exist.

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Treatment of Undulant Fever With Streptomycin

By JOHN R. GOELZ, M. D.

De Pere

J. R. GOELZ

A 1940 graduate of Marquette University, Doctor Goelz had hospital training at the University of St. Louis Group of Hospitals. He is now associated with the De Pere Clinic.

Doctor Goelz is a fellow in the AMA.

A NEW and favorable drug has been added to the list of therapeutic agents used in treatment of undulant fever.

Up to the present, undulant fever has proven to be a stubborn disease, resistant to practically all therapy, except occasionally the sulfa drugs in acute cases. With the introduction of streptomycin, it is probable that a more effective cure can be had in treating this destructive disease, at least if the diagnosis is made in the early phases. This becomes of considerable importance when one realizes the great possibilities of infection of undulant fever in humans, due to the prevalence of Bangs Disease in our dairy herds throughout the state.

Streptomycin is an antibacterial therapeutic agent, particularly effective against many gram-negative organisms, including those which are not affected by penicillin. It is prepared by culturing the actinomycete Streptomyces griseus in a media from which streptomycin is then extracted.

The method of application is usually by continuous drip or intermittent muscular injections in such doses as to maintain an effective antibacterial concentration in the tissues. However, oral as well as subcutaneous administration has therapeutic value. The dosage depends on the type of infection, its severity, and location.

Ordinarily no ill effects are present with the use of streptomycin. If given in very large doses, transient, histamine-like reactions can occur—namely headache, flushing, a drop in the blood pressure, and fainting sensations.

Report of Case

E. A., a man of sixty years, became ill on August 20, 1945. He complained of marked general malaise, anorexia, headache, aching joints, and chills. This progressed, and on the evening of the seventh day I was called to the patient's home. Examination revealed a very ill-appearing male. He was flushed and perspiring profusely. His throat appeared moderately injected, both lung fields were clear, no rales were illicited. There was a slight degree of tenderness in the upper left abdominal region. The pulse was 98, and the temperature 104.4 F. With this clinical picture, and in the absence of positive physical findings, it was assumed that the patient was developing an influenzal pneumonia. He was sent into the hospital that night, and started on penicil-

lin and sulfamerazine with supportive therapy. The next morning laboratory tests revealed a leukopenia of 6,600 with 35 per cent lymphocytes present. A trace of albumen was found in the urine. Agglutination tests and a blood culture were then ordered, and revealed a positive agglutination for undulant fever in dilution of 1/320. Blood culture was negative.

The patient was continued on penicillin—20,000 units every four hours, and sulfamerazine 7.7 grains every four hours. On the third day of this treatment the patient felt some better and his fever lowered to 100.2 F. On the fifth morning his temperature elevated to 104 F., and the penicillin and sulfamerazine were discontinued. The patient appeared extremely weak, and complained of an intense headache and profuse perspiring. Then streptomycin was started—65,000 units were given every three hours intramuscularly, until a total of 1,000,000 units was administered. Within twenty-four hours a clinical response was noted. The following day the fever descended to 98.4 F., and has remained consistently normal since that time. Clinically the patient showed a progressive improvement of appetite and strength. A follow-up of the case since discharge from the hospital reveals a normal temperature and a return to a healthy status.

Summary

A case of undulant fever in the early stages is presented, which failed to respond to penicillin and sulfamerazine, but improved promptly with the administration of streptomycin.

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Physical Examination of School Employees With Special Reference to Tuberculosis*

By A. A. PLEYTE, M. D.

Milwaukee

Why Should School Employees Be Examined?

COMMUNICABLE diseases can be spread in our schools. It is most essential therefore that teachers, employees, and students be watched continuously for evidence of illness which may be transmitted to others.

Other abnormal conditions such as defects and chronic infections may be present in adults and children. These structural changes do not always make themselves known to the individual in way of symptoms and signs. In fact, several of our more serious afflictions are often present for long periods of time, because the victim does not feel ill. How often diabetes, heart defects and disease, apoplexy, cancer, tuberculosis, goiter, and Bright's Disease are found in persons who have not suspected their presence. Fortunately, these diseases can usually be controlled if found in time, but on the other hand because they are stealthy in onset, these maladies rank high in the causes of death in human beings. Teachers and school employees are vulnerable to communicable disease, defects and serious illness even as other humans are vulnerable to these plights. But it is particularly important that school personnel be healthy not only that they may give of their best efforts in the school room, but that they may protect the health of the children who are compelled to go to school.

History and Present Status of Health Examinations in the United States and in Wisconsin

Health examinations are not new. They have been in vogue many years. But we find even today considerable variance in what is considered an adequate examination. For example, many times a teacher presents a certificate of health for employment in our schools without proof that he or she is free from tuberculosis. This is unfortunate because school personnel *does have* this disease. Actual case-finding studies in various parts of the country reported by Dr. H. D. Lees, University of Pennsylvania in the June, 1936, Bulletin of the National Tuberculosis Association, showed that of 6,066 teachers studied in New Haven, Connecticut, Macon County, Illinois, Minneapolis city schools, Minnesota rural schools, the State Normal School of Belling-

* Prepared at the request of the Committee on Tuberculosis and Chest Diseases.

ham, Washington, and the University of Pennsylvania School of Education, 131, or 2.15 per cent, were found to have pulmonary tuberculosis. If this incidence were true for the 871,000 teachers in the elementary and secondary schools in the United States, we would have upward of 18,000 tuberculous teachers in active service in our schools in this country according to Doctor Lees. On the same basis, Wisconsin would be estimated to have approximately 600 tuberculous teachers in active service.

That teachers may pass on their tuberculosis to their pupils is demonstrated by the following case report from a Wisconsin physician. He writes this story of his youth: "There were 31 students in our graduating class in high school. All through our senior year we had a teacher who taught several classes of students who was clearly sick. His work also required many intimate conferences with these students. He taught until the end of the school year which would be June 28 or 29. On July 5 of that year he died of pulmonary tuberculosis, presumably of hemorrhage, only 6 or 7 days after the close of school and the last day of teaching. Out of that class of 31 students 6 or 7 contracted some form of tuberculosis and at least 4 of them have died of the disease."

Much higher percentages of reactors to the skin tuberculin test are found in classes where teachers have been detected with tuberculosis. Jordan reported in the Journal-Lancet, April, 1936, that in a study in Minnesota of 64 pupils exposed to a teacher with far-advanced tuberculosis, 46 per cent were positive to the Mantoux tuberculin test. In contrast, of 161 other pupils not exposed to this teacher, only 11 per cent were positive. These two groups of children were from the same school, the same age group, and the same home environment.

Doctor Lees declares that "tuberculosis among students in classes taught by teachers suffering from this disease is 2½ times greater than classes where instructors are free from the ailment."

In connection with the National Tuberculosis Association's annual meeting at Saranac Lake in June, 1935, a committee on tuberculosis of the American Association of School Physicians agreed upon the following recommendations: "That the personnel, including teachers, engineers, clerks and everyone coming in contact with children, be adequately examined for tuberculosis. This examination should consist of: First, a tuberculin test and chest films of positive reactors or, in lieu of the test, for those who object to it, x-ray films be required; that all who show shadows suggestive of pulmonary tuberculosis have very careful clinic and laboratory examinations to determine whether the disease is progressive or whether tubercle bacilli are being eliminated through the sputum; that all members of personnel who have progressive tuberculosis or tubercle bacilli in the sputa be granted leaves of absence until their disease can be satisfactorily controlled, and the sputum rendered negative for tubercle bacilli; that all members negative to the tuberculin test be re-tested annually and those who refuse the test have x-ray films made annually; that every person seeking employment in a school system be adequately examined for tuberculosis . . ."

In a questionnaire sent out to the schools in Wisconsin in 1942 for the tuberculosis committee of the American Student Health Association, it was found that, "Provision for chest x-rays of school personnel appears to be on the increase in Wisconsin school systems. In view of the far higher morbidity and mortality rates among adults than among school children, there can be little question that provision for such diagnostic procedure is a forward step, and urgently to be recommended."

Last year the Los Angeles County Tuberculosis and Health Association mailed a questionnaire widely throughout the United States, on "Are Health Examinations Required of School Employees?" Two hundred questionnaires were returned from 34 states, showing the trend of health examinations including proof that employees are free from tuberculosis.

Quoting from the Los Angeles County "Facts for Action" Vol. I, No. VII, September, 1945: "*In 18 states* there is a law pertaining to physical examination of school employees. It is applicable to *all employees* in 10 states, to *teachers only* in 7 states, and to food handlers only in 1 state. Preemployment examinations are mandatory in 15 states. *In 13 of these states, laws call for specific examination for tuberculosis.* Six states reported good enforcement of the laws. In 11 states, employees were required to furnish evidence of physical fitness periodically, the time interval varying from 1 to 5 years. Nine states required that the examination include evidence that the employee is free from tuberculosis.

"*Only 77 localities responded to the question regarding the inclusion of a chest x-ray in the physical examination.* Of those, *70 per cent included such examination.* Very few districts required that a chest x-ray be submitted following illness.

"Laws requiring preemployment physical examinations including examinations for tuberculosis of school personnel are reputed as effective in Illinois, Indiana, North Carolina, New Jersey, Oregon, Washington and Washington, D. C. With the exception of Illinois and New Jersey these states require periodic examinations in addition to preemployment examinations. The aforementioned legislation applies to teachers only in Oregon. North Carolina includes food handlers as well as teachers. Legislation providing for thorough physical examination became effective in Maine and New Mexico this year. Other states have similar statutory legislation, but it is less comprehensive. *Still other localities have good tuberculosis programs without state laws.*"

In conclusion the Los Angeles report states: "*Health programs applicable to school personnel vary widely and it is impossible to determine from the data collected if centralized official control or local voluntary regulation is more successful.*"

Does Mandatory Regulation of Tuberculin Testing and X-Raying of the Reactor Group Invade the Constitutional Rights and Privileges of School Employees?

According to a recent decision of the New York State Supreme Court Justice, Mr. Sweezey, in a case brought against the New York City Board of Education and the New York City Department of Health by a joint committee of teachers' organizations in New York City, found that the teachers' rights must yield to the common good. The Board of Health of New York City requires teachers and other employees who work in the schools and come in contact with the children to procure bi-annually a certificate from a physician or from the Board of Health based on a chest x-ray examination and certifying that such employee is free from active tuberculosis. Mr. Justice Sweezey concluded that the legislature had properly delegated the power to regulate the public health to the Department of Health of the City of New York within certain limitations. He said in part, "Our courts have consistently held that the natural right to life, liberty, and the pursuit of happiness is not an absolute one, but that it must yield if the sacrifice is necessary in order that organized society as a whole is to be benefited."

In Wisconsin the State Department of Health provides that "No person suffering from pulmonary tuberculosis or believed to be suffering from pulmonary tuberculosis when reported to the health officer as provided for in Section 143.06 of the statutes shall be permitted to attend or frequent public, parochial or private schools, except open air schools especially equipped for such pupils in this state, in the capacity of pupil or teacher until the health officer or one of his deputies of the township, incorporated village or city, where the school is located furnishes a written certificate stating that the individual believed to have pulmonary tuberculosis or suspected of having pulmonary tuberculosis is free from the disease."

There may be some reason to doubt a school board's authority to enforce a Board of Education's edict which practically orders chest x-rays for all school employees. However, if such a specification is part of the contract for work in a given school, it should be enforceable. Surely it is reasonable that existing contagious disease is cause for rejection in hiring or continued employment when found to exist.

In November, 1944, the State Board of Health issued the following statement: *"Compulsory Examination by X-Ray of all Food Handlers and School Employees*—The desirability of having all school employees, teachers, janitors, etc., show freedom from tuberculosis by means of x-ray was agreed upon. The question of requiring an x-ray of all food handlers because of the inaccessibility to x-ray equipment in some sections of the state and for other reasons was considered to be a complicated problem and referred for further study."

The Situation in Wisconsin

While much has been accomplished in Wisconsin in an educational and demonstrational program in way of physical examination including chest x-ray for school employees, there has been no uniform action taken by school boards in such procedure. In Milwaukee when teachers are employed as substitutes, they receive a complete examination including a chest x-ray film. A similar examination is required at the beginning of their three-year probationary period and again before being placed on the permanent teaching staff. Other employees also receive a complete examination at time of employment. Both teachers and other employees are required to be reexamined before returning to work following a prolonged illness. About 80 per cent of school personnel respond voluntarily for skin tuberculin tests and chest x-rays if found to be reactors, when surveys are held at their school. But there is no provision for regular examination including a chest x-ray film at periodic intervals after employees are on a permanent employment basis.

In Whitefish Bay all school employees are required to comply annually with the tuberculosis survey of the local Department of Health. In 1945 the School Board agreed to pay the cost.

In Spooner, teachers, janitors, and bus drivers may take the skin tuberculin test with follow-up x-rays for reactors, at a cost of $1.50 per film, or furnish evidence from the family doctor as to freedom from tuberculosis.

In Shorewood all employees under 30 are examined yearly, over 30 every three years. Employees are tuberculin-tested, and fluoroscoped if found to be reactors, at the expense of the board. If the employee refuses the skin test and asks for his immediate x-ray examination, then the employee must pay the cost.

Bayfield County requires teachers and school employees to have a tuberculosis examination in accordance with action taken by the County Health Committee. Procedure is annual and not necessarily preemployment. It is part of each teacher's contract. The examination consists of a tuberculin test and x-ray of the reactors. This x-ray may be taken at the sanatorium at a cost of $2 paid by the individual.

They feel in Bayfield County that, "If ALL employees are so checked, we can assure the parents that no child will contract tuberculosis as a result of his association with teacher, bus driver, cook or janitor.

"The school employee should have this annual examination for the sake of his own health as well as to show consideration for the health of fellow workers and students. One employee with active tuberculosis can be the cause of infection and dis-

ease in both the pupils and in the other school employees."

"It is mandatory that our children attend school, therefore it is up to us, the Health Department and the school boards, to make our school a safe place in which to be."

In Ashland the Board of Education requires proof as part of the teacher's contract that the applicant is free from tuberculosis. Such evidence must include a negative skin tuberculin test or a chest x-ray which is negative to active disease. In the event that neither the skin test nor the x-ray is positive, the x-ray is to be repeated annually or oftener if in the judgment of the City Health Officer more frequent x-rays are advisable. All x-rays are submitted to the City Health Officer for examination.

In another small city the health nurse approached various teachers in the local school to see what their reaction might be toward compulsory health examination for teachers and other school employees. In this instance, all teachers reacted favorably to the suggestion. The school superintendent and principal were next approached and then the members of the Board of Education. In every instance the suggestion was thoughtfully and sincerely accepted as the answer to one more serious school health problem. This nurse writes that they just hadn't realized the importance of an annual tuberculosis examination. She stated, "Finally the Board of Health sent a formal request to the Board of Education that all teachers and school employees must have an annual chest x-ray and that all new employees submit chest x-ray reports with their contracts." This program went into effect in April, 1945. She concludes, "We sincerely believe that the enthusiastic acceptance of this program was due to the fact that these employees were consulted beforehand instead of having such a surprise regulation thrust upon them. For the good of themselves, as well as the children placed under them, we know that they will continue to support this program willingly and wholeheartedly."

Attitude of the Committee on Tuberculosis and Chest Diseases of the State Medical Society of Wisconsin

The Committee endorses the recommendations of the Committee on Tuberculosis of the American Association of School Physicians. These are quoted earlier in this resumé.

It is also suggested that educational campaigns for the prevention of tuberculosis be actively supported by the society. Teachers and other employees need to be approached by nurses and physicians to the end that they see the necessity for periodical examination including proof of freedom from communicable disease.

We feel that permissive legislation which would make it possible for school boards to expend necessary monies for an adequate program of physical examination including a chest x-ray film annually of all school personnel to protect children and other employees, is sound public health procedure. We recommend such legislation.

PARTICIPATING IN POSTGRADUATE TEACHING CLINICS

H. M. COON

The 1946 Clinic programs have been arranged by Dr. Harold M. Coon, Madison.

Have you registered and chosen your round table? If not, do so today, as individual groups for round tables cannot exceed thirty physicians.

W. S. MIDDLETON

W. S. Middleton, M. D., Professor of Medicine and Dean of the University Medical School, Madison, will serve as moderator of the 1946 Postgraduate Teaching Clinics.

W. C. KEETTEL

After several years of army service Dr. William C. Keettel, former consultant with the State Board of Health, is returning to present papers on obstetrics and gynecology at the June Clinics.

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Folic Acid in the Anemias

History—In 1935 Day et al, of the University of Arkansas, reported that there developed in young rhesus monkeys on a synthetic diet a certain type of severe deficiency syndrome which was correctible by addition to the diet of brewer's yeast or liver extract. They proposed that the title "vitamin M" be given to this unknown nutritional factor. Several years later, Snell and Peterson (1945), of the University of Wisconsin, found that the substance "norite eluate factor," which they extracted from yeast or liver extract, was essential for the *in vitro* growth of the organism *Lactobacillus casei.* These two isolated observations were put together five years later by Day's group (1945) when they found that the *L. casei* factor is curative in their vitamin M deficiency in monkeys. Very soon thereafter Angier et al (1945), of the Lederle Laboratories, synthesized crystalline folic acid, which is apparently identical with the *L. casei* factor, and made it available for clinical trial by selected groups of investigators.

Use in Sprue—Vitamin M deficiency in the monkey, which is characterized by anemia, leukopenia, loss of weight, ulceration of the gums, diarrhea and death, seems to be the approximate equivalent in the animal of the sprue syndrome in man. This being so, Darby et al (1946) of Vanderbilt University, and Spies et al (1946), of the Hillman Hospital in Birmingham, set about testing the new folic acid in the human disease. Taken together, their reports comprise a study of twelve cases, in all of which the treatment was apparently completely successful. The patients rapidly gained in body weight and in strength on folic acid, the macrocytic anemia was fully corrected, glossitis disappeared, and there was a return of the stool toward the normal type. The conclusion of these two groups of workers was, therefore, that folic acid may be employed in sprue with the likelihood of obtaining fully as great effects as from the use of a potent liver extract.

Use in Macrocytic Anemias—Since the macrocytic anemias of both vitamin M deficiency in the monkey and of sprue in man have been found to be easily correctible by the use of folic acid, as above described, it became logical to try the new agent in other macrocytic anemias in the human patient. Spies (1946) and his group at the Hillman Hospital have now reported such trials in a series of 45 patients with pernicious anemia, the macrocytic anemia of pellagra, the macrocytic anemia of pregnancy, and nutritional macrocytic anemia. In all instances folic acid evoked fully satisfactory responses whether given by mouth or injected intramuscularly. The anemias were corrected and the immediate subjective and objective responses of the patients were apparently quite similar to those following the employment of liver extract in usual dosages. However, in the case of pernicious anemia there is nothing in Spies' report to indicate whether folic acid will prove as effective as liver extract in maintaining a normal blood picture, nor can any notion be gained from this preliminary work of the agent's potentiality for protecting against involvement of the nervous system.

Use in Other Anemias—In addition to its employment in the macrocytic anemias, Spies and his group tried folic acid in cases of anemia associated with leukemia, in aplastic anemias, in iron-deficiency anemias, and in a group of other anemias of undetermined origin. In no instance was improvement effected in these patients.

Summary—It may be that in folic acid we are about to have made available to us a synthetic substitute for liver extract in the treatment of pernicious anemia, of the sprue syndrome, and of anemias of the macrocytic type in general. There is no evidence, however, that anything is to be expected of the agent in any of the other anemias.—HARRY BECKMAN, M. D.

Notes on Clinical Pathology

Editors—WALTER H. JAESCHKE, M. D., University of Wisconsin, Madison, and
S. B. PESSIN, M. D., Marquette University, Milwaukee

The Diagnosis of Malaria

Interest in the diagnosis of malaria has received new impetus because of the large number of returning service men who have contracted chronic malaria. Although the symptoms of malaria are often typical, it is always well to confirm the diagnosis by laboratory study. At the present time the laboratory diagnosis depends upon finding the parasites in the peripheral blood. Since malaria severe enough to produce symptoms always shows evidence of plasmodia in the peripheral blood, the failure to find either parasites or malarial pigment after careful search is strong evidence against the clinical diagnosis of malaria. Once treatment has begun, or in the interval between relapses when symptoms are not present, the parasites may be so few in number that they cannot be found. Examination of smears under these circumstances is usually futile and a negative result has no meaning.

Both thick and thin blood smears should be examined before a negative result is accepted. Several smears may occasionaly be necessary before the parasites can be found. The thin blood smear is made in the same manner as the smear for a routine differential count. The thick film is made by placing 2 or 3 average-sized drops of blood on one end of a glass slide which has been cleaned by soaking in alcohol and wiped dry. These drops are then pooled with the corner of another slide or with a needle so that a thick homogenous drop about the size of a dime is formed. The thickness of the puddled drop is important since one that is too thick will crack and peel off the slide during staining while too thin a drop defeats its own purpose. Ordinary printing can just be read through the wet center of a well-made thick film when the slide is placed over the printed page. The smear is allowed to dry thoroughly (about one hour at 37 C.) before it is stained. Giemsa stains may be used for both the thick and thin smears. Use of the thick drop smear increases the chances of finding parasites by 8 or 10 times.

Malarial parasites are most numerous in the peripheral blood at the end of the febrile phase of the paroxysm. However, they may be found at other times, and there is no reason to delay making the examination when the patient is first seen. It should always be borne in mind that in *P. falciparum* infestations the non-sexual form of the parasite is present in the peripheral blood only during the first eighteen to twenty-four hours following the paroxysm. The sexual forms are always present, but they are often very few in number. Therefore, in cases of suspected falciparum infestation careful attention to the timing of the paroxysm and making the blood smear will be necessary.

Examination of the blood smear is not difficult as long as one knows the morphologic appearance of the parasites and takes care not to confuse platelets, precipitated stain, debris, and bacteria with malarial parasites. In thin smears no object lying outside of a red blood cell should be called a parasite. In the thick film examination special care is necessary as the red blood cell is dissolved. A little time and study should make the conscientious technician capable of using thick films, and the results will be well worth the effort needed to master the technic.

The number of parasites in the peripheral blood may be increased by physical exercise, exposure of the splenic area to ultra-violet rays, or the hypodermic injection of 1 mg. of adrenalin. The latter method is the most satisfactory, the parasites making their appearance in the peripheral blood within half an hour following the injection and reaching their maximum in an hour. These methods are sometimes useful in confirming a diagnosis of latent chronic malaria. Splenic and sternal puncture have been recommended by some authorities as methods for proving a diagnosis of chronic malaria. Neither of these methods is without danger and their use is seldom justified until all other methods have failed. At the present time complement fixation and culture technics are not satisfactory for the routine diagnosis of malaria.—EDWARD A. BIRGE, M. D., *State Laboratory of Hygiene.*

. . . . THE PRESIDENT'S PAGE . . . .

That Existing Conditions May Be Known

A WISE wag once said that there are three kinds of lies and the third kind is statistics. He referred, of course, to the false type of statistics usually employed in promotions when the whole truth would not help the enterprise. Figures, misbranded statistics, may be true in a limited sense but if false when viewed in the full amplitude of a particular subject are wholly untrue and misleading with reference to a healthy evaluation of that subject. To be valuable statistics must be factual with respect to time and place, must be honestly assembled and must be exhaustive and comprehensive. To be factual implies painstaking reporting of complete actualities. Any dissertation of statistics is incomplete if no explanation is given concerning the surveys that produce the figures. A survey is the effort that compiles the summary, and the product is always in keeping with the moral integrity and mental handiwork of the surveyor. Some individuals have been known to compile statistics as they surveyed the whole country from the vantage point of a stuffed chair by an ornate table at the headquarters of some federal bureau. Statistics, emanating from such authors and surveys, are being employed to destroy public confidence in American medicine so that autocratic, compulsory, political medicine may take its place. There are two bills now before Congress which, if enacted into law, will shatter the foundations of American medicine and jeopardize our whole political and social structure as well. Though not so well known as the Wagner–Murray–Dingell bill, the Pepper measure is fully as dangerous since it would make all persons under twenty-one years medical wards of government. The American Academy of Pediatrics is fully aware of the dangers inherent in this bill and has asked for the cooperation of all physicians in exposing all its flagrant features. The proponents of the measure have put forward an avalanche of statistics purporting to be the summation of certain surveys. These figures and surveys are seriously questioned on the basis of accuracy and veracity. That the truth may be known, the Academy is seeking to develop a complete picture of the field of pediatrics by promoting an honest, complete, painstaking investigation. Dr. H. Kent Tenney, of Madison, is in charge of this work in Wisconsin for the Academy and should be actively aided in his work that the existing conditions may be known to refute the falsity of selfish guessing and fictional surveys.

P. R. Mirahan

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« « « EDITORIALS » » »

Introducing the Guest Editorialist

A NATIVE of Texas, Jim Dan Hill came to Wisconsin twenty years ago to accept the chairmanship of the department of social sciences, River Falls State Teachers College. He was appointed President, State Teachers College, Superior, in 1931.

He has the conventional university, professorial credentials of A. B., M. A., and Ph.D. He has followed the almost equally conventional pattern of scholarship by writing educational articles, reviews, and two books, these last in the fields of naval history and diplomacy. He is also active in the historical and educational associations pertinent to his profession.

Beyond the foregoing, the career of Jim Dan Hill bears little resemblance to that of a career pedagogue. He served overseas in the Navy during World War I, and later briefly returned to the sea on merchant ships to acquire a third mate's license. He then switched his extra-curricular activities to the military by affiliating himself alternately with the Officers Reserve Corps and the National Guards of New Mexico and Wisconsin.

He was inducted into active duty October, 1940. During the five years that followed, Colonel Jim Dan Hall side-stepped swivel chair assignments, more or less in line with civilian experience, to retain an artillery command throughout World War II. He returned to duty at Superior in November, 1945, after three years of overseas command duty, eleven months of it in combat, during which he flew over fifty air-artillery observer missions in cub planes. Among other decorations he holds the Air Medal, Bronze Star Medal, Legion of Merit, the French Croix de Guerre, and Chevalier, Legion d'Honneur.

Thus to the readers of *The Wisconsin Medical Journal* is introduced President Jim Dan Hill, whose guest editorial following was prepared especially for the physicians of Wisconsin.

On Medical Progress

DOCTOR STAFFORD of London was a good friend of Governor Winthrop of Massachusetts. The last named, one of the most learned and enlightened men of his day, was mildly interested in simple cures for his colonists. From Stafford he received a prescription which was for "small-pox, plague, purples and poison." It reads as follows: "In the month of March take toads, as many as you will alive, putt them in an earthen pott, so that it may be half full; cover it with a broad tile or Iron plate; then overwhelme the pott so that the bottom may be uppermost; put charcoales around about it. . . Set it on fire and lett it burn out and extinguish itself; when it is cold, take out the toades; and in an Iron mortar pound them very well. . . Moderate the dose according to the strength of the partie." The date of that prescription was 1643.

About the same time throughout England it was generally believed that sufferers from "epilepsy and scrofula" would find relief if touched by the royal hand. Charles II is said to have touched nearly 100,000 during his thirty-five year reign. Richard Wiseman, one of the ablest English surgeons of the century, declared that "I myself have been a frequent eye-witness of many hundreds of cures performed by his Majesty's touch alone."

Thus, the Virginia colonist probably wasn't too far wrong when he wrote that the American Indians had splendid medical men and were "as able physicians as any in Europe." That letter, with the many more like it from subsequent generations, were most likely responsible for so many Indian remedies being sold in Europe up to and including the past century.

Only a short one hundred years ago, as history records time, medical scientists were disturbed over the progress that exponents of hypnotism and mesmerism were making as practitioners of curative powers. Mesmerism was sometimes proposed as a pain killer, sufficiently potent to permit surgical operations. This was the status of affairs when the scientists at the University of Edinburgh heard of the successful work of Jackson and Morton, one a physician and chemist, and the other a dentist, in Boston.

Liston, after some practical experimentation of his own, wrote to one of his old students: "Hurrah! Rejoice! Mesmerism and its professors have met with a 'heavy blow and great discouragement.' An American dentist has used ether (inhalation of it) to destroy sensation in his operations, and the plan has succeeded in the hands of Warren, Hayward, and others, in Boston. Yesterday, I amputated a thigh . . . without the patient's being aware of what was doing, so far as regards pain."

About ten years earlier, according to *Niles Register,* Nov. 18, 1837, the New York Journal of Commerce reported "a letter from the captain of the ship Nestor, and hence at New Orleans, states that of 212 passengers who went out in that ship, 162 died previous to October 4, chiefly of yellow fever; and that on the 19th, only ten of the whole number survived."

Where did I pick up the foregoing? From a Medical Corps lieutenant colonel, who had long practiced in Pennsylania before entering the service. He used to intersperse his conversation with these and many more oddities from medical history.

One day I asked him why he had seen fit to clutter up his mind with such entertaining but apparently unusable information.

The colonel's explanation was brief but its moral evident. His purchase of a deceased colleague's practice had brought him a number of cynical, garrulous and ofttimes critical hypochondriacs, one of whom never lost an opportunity to express his opinion that medical science had progressed but little, otherwise it might well effect his permanent cure. "If I answered with showing the progress since my own graduation," said the colonel, "I merely impressed him that I was trying to keep up to date. Thus my efforts to know the history of medical progress."

To live as contemporaries one of another is inevitable. But to enrich our lives and the lives of those with whom and for whom we work, is to contribute to an appreciation of our relative progress over the years. Used wisely such will not produce either lethargy or supine contentment—it will, on the contrary, evidence continued devotion to the attainment of the further good of mankind.

Jim Dan Hill

RETIREMENT OF DR. OLIN WEST, SECRETARY-GENERAL MANAGER*

According to the official announcement from the Board of Trustees which appears elsewhere in this issue, Dr. Olin West, Secretary-General Manager of the American Medical Association for more than twenty-three years, retires from his official duties on April 1. The intense devotion of almost a quarter of a century of unremitting diligence in behalf of the progress of the American Medical Association and of its policies for the maintenance of medicine as a profession has taken a considerable toll of his energy.

Dr. Olin West came to the American Medical Association with a record of experience in medicine and public health that especially fitted him for the positions that he assumed. His preliminary education was received at Howard College in Alabama, in which state he was born at Gadsden on July 12, 1874. He graduated from Vanderbilt University School of Medicine, Nashville, Tenn., in 1898. In 1910, after twelve years of practice in Nashville and fifteen years as a member of the faculty of Vanderbilt University, first as instructor and later as assistant professor and associate professor in chemistry, Dr. West became director for the Rockefeller Sanitary Commission and International Health Board in Tennessee. Here he was especially effective in the great campaign against hookworm infection. In 1918 he became secretary and executive officer of the Tennessee State Board of Health and after four years gave up that position to become field secretary of the American Medical Association in association with Dr. Alexander Craig, who was at that time Secretary. Following the death of Dr. Craig, Dr. West was appointed Secretary by the Board of Trustees. Then when Dr. George H. Simmons resigned as Editor and General Manager of the Association in 1924, Dr. West continued in the position of Secretary and succeeded to the duties of General Manager.

In early activities for the organized medical profession Dr. West was president of the Middle Tennessee Medical Association and later secretary of the Tennessee State Medical Association and editor of its journal. His love for the art and tradition of medical science, his great personal compassion, his geniality and his friendliness have endeared him personally to many thousands of American physicians who have met him in office and who have had advantage of his personal counsel and judgment.

The *Journal* wishes to Dr. West on his retirement many years of healthful life and many hours in which he can devote himself to his family and his friends, realizing at the same time that his interest in medicine and particularly in the advancement of the American Medical Association will never lag. Certainly the committees and the councils of the Association will continue to utilize as far as possible the experience and the judgment which have meant so much toward achieving the high place that the American Medical Association occupies today among medical organizations throughout the world.

* Reprinted from the J. A. M. A. 130:858 (March) 1946.

DIRECTION NEEDED . . . AND ASKED FOR

One of the phenomena of modern fund-raising is the record established by the National Foundation For Infantile Paralysis. The appeal for the care of crippled children is one which opens the pocketbooks of the American public. While the problems of cancer and cardiac diseases involve many more lives than those suffering from poliomyelitis the fact remains that the National Foundation has touched a well spring from which has flowed many millions spent to aid in the fight against this affliction.

Wisconsin has shared in this annual philanthropy, with $265,000 collected in the recent 1945 campaign. While half of these funds are allocated to the national office for medical research and to provide funds for areas in need of funds beyond their existing treasuries, the remaining $132,500 is left with local Wisconsin chapters to meet the needs of poliomyelitis victims in this state.

Those directing the national and state programs of the Foundation are alert to the need for close correlation of their work with existing medical organizations. County units of the Foundation are urged to interest local physicians who will serve as members of county medical advisory committees.

To date the response of the profession has been spotty. In areas where physicians have taken an active interest in the program and have advised with lay leaders as to the wisest expenditure of funds much good has been accomplished.

Many times the profession has been critical of lay people determining medical care programs. Such criticism is justified, but not if the profession ignores the invitation to sit in and direct the medical aspects of the program.

Those most directly concerned with the care of poliomyelitis patients in Wisconsin feel there is great need to educate the public and those responsible for the administration of hospitals as to the effectiveness of isolation of poliomyelitis, and how it can be handled in a well equipped general hospital without danger to other patients. Public health officials are interested in developing a program of care which will avoid the annual overload of polio patients in Madison and Milwaukee, while localized facilities adequate to administer hospital care are passed by. The National Foundation is actively interested in providing more and better trained physiotherapists who could carry on the emergency care of polio patients in various parts of the state. It's just common sense that the medical profession should assist by way of directing the program along sound medical lines.

The *Journal* has, upon numerous occasions, urged its members and affiliate county units to work with lay groups interested in programs involving medical care. This same feeling is expressed to such an organization as the National Foundation, which is seeking advice through the formation of medical advisory committees.

PLACEMENT SERVICE FOR PHYSICIANS IN INDUSTRIAL APPOINTMENTS

With demobilization following the war, one of the early services of the Wisconsin profession, working in cooperation with Procurement and Assignment and the State Board of Medical Examiners, was the development of placement services for the returning veteran. The entire state is maintained in current survey, and through the Society's office, as well as through the *Journal* itself, a great deal has been done to assist the veteran physician and the community alike.

The Council on Industrial Health of the American Medical Association has recently announced a placement service for physicians interested in industrial appointments. It has advised manufacturing and commercial agencies, as well as press representatives, that every effort should be made to fill such vacancies locally if possible through contacts with the county society or the State Medical Society. If neither of these proves productive, the Council itself will make available suggestions from material it has gathered from interested physicians, who are requested to contact the Council giving full details relative to their medical school, licensure, special training, and experience.

This is a wholesome step on the part of the A. M. A.'s Council on Industrial Health. Physicians in Wisconsin who may be interested in such openings are urged to cooperate.

EVER SHAKE A JAR OF BEANS?

It was once observed that power ever steals from the many to the few. There has been many an historical event to prove this statement a virtual platitude. Nor do contemporary days lack similar events.

Physicians of the United States would do well to think of some pending legislative proposals in this light, and foremost among them might be listed that which currently bears the number S. 1606—the Wagner–Murray–Dingell bill.

If by misfortune it should become the law of the land, huge power to regulate the health of the people will become vested in agencies of the federal government. The Surgeon General of the United States Public Health Service will be the dictator of medical practice, specialist practice, and hospital practice. According to reliable estimates, more than 110,000,000 persons would be covered by the legislation, and having contributed from their pay, would seek whatever measure of care was their due. The Surgeon General would be empowered to control that service through physicians paid on a per capita basis, a fee basis, a part or whole time salary basis, or a combination of those methods. Thus, the Surgeon General would hold the purse-strings over health in our country.

Ever shake a jar of beans? Ever notice that the big ones come to the top and hold a leveling influence on all the rest?

A FUMBLE ON THE GOAL LINE?

A recent communication received at the Bureau of Maternal and Child Care of the State Board of Health presents a situation which has possibly become disturbingly frequent during these years of war stress and overwork on the part of civilian practitioners. An expectant mother in rural northern Wisconsin expresses interest in the pre-natal literature distributed through the Bureau and says in part:

> "There is something I'd like to ask your opinion on. On Jan. 8th I went to my doctor and he told me I won't need to come back till my time is up, and that is the last of March. He has never taken any measurements of me, and it seems as if a doctor would want to check with a person. It has been 13 years since I had have moved too far from our former home."
> moved too far from our former home."

Recognizing the difficulties under which the majority of practitioners have worked these past few years it is not difficult to understand these problems. But for years the medical profession in Wisconsin, as elsewhere, has encouraged the annual physical examination, frequent examinations for cancer detection, and the value of pre-natal check ups. Over the years the public has been educated to the viewpoint that life can be made more enjoyable and last longer if periodic medical care is given. It has resulted in many down curves in statistical indications of public health. But the faith of the public may be shaken if, under the stress of heavy work schedules, physicians discourage those who seek examinations without specific complaints, and those who ask for more than a single examination and consultation during pregnancy. Admitted that hours are long, and every physician has a certain percentage of neurotics who are constantly demanding attention. Efforts should be made to weed out those who enjoy ill health and revel in medical consultation. There are others who have accepted the philosophy of preventive medicine in good faith and are merely putting into sensible practice the very things medicine has been preaching for the past several decades. Sincere efforts should be made to give services of preventive medicine to those who have attained a commendable consciousness of its importance.

It would be too bad to fumble the ball on the goal line. Too often a fumble means the loss of the game.

As It Looks to Your State Board of Health

(These timely discussions of health problems are prepared by staff members as a special service to Wisconsin's physicians.)

Smallpox

The appearance of a severe type of smallpox in west coast ports of the United States, introduced by soldiers returning from the Orient, is cause for looking into the vaccination status of Wisconsin residents. Prior to the Spanish-American War the type here was, in general, severe as indicated by the high death rate in proportion to number of cases. Since that time the mild type has mainly prevailed, declining during the past decade. In 1924 the malignant type of smallpox gained entrance by inheritance from a neighboring state and mounted in the following year, resulting in 530 cases and 127 deaths in 1925. A great many people became alarmed and there was very wide vaccination of children and adults throughout the state for a time. There is no indication that any great amount of vaccination has been done among adults since then except among children and in some industrial plants. School children have been offered vaccination in county and city programs every year, with a high proportion being vaccinated. There is much neglect, however, of vaccination of pre-school children as shown by annual statistics reaching the State Board of Health. From all appearances it looks as though a large part of the adult population has not been recently vaccinated, which opens the way for an invasion of the serious type of smallpox. Vaccination protects for a variable time. It may be for four or five years or it may be 20 years or more. A partial immunity protects or may not, depending on the degree of exposure and type of disease. Vaccination records obtained on 516 out of the 530 cases during the malignant smallpox outbreak in 1925 showed the following:

Never vaccinated (80.1% of total cases)	427
Vaccinated less than 5 years	1
Vac. 5 to 10 years previous	9
Vac. 10 to 20 years previous	23
Vac. longer than 20 years	56
	516

To be on the safe side, vaccination should be performed at least, according to the usual dictum, every five years.

The multiple pressure method of vaccination now in common use has been found to be much less liable to produce septic complications than older methods. Much appears in the literature on the terms "accelerated reaction" and "immune reaction." An accelerated reaction means that the resultant vesicle following vaccination is small and assumes its maximum size in four to seven days, then begins to disappear. In other words, it is a quicker reaction and smaller in size than normal. It indicates partial immunity. The immune reaction which is sometimes called "immediate reaction" consists of a small papule and small red areola, reaching its maximum size in one-half to three days with a prompt disappearance. In other words, a small papule with a very limited inflammation occurs and disappears before a reaction would normally appear. It indicates a high degree of immunity. Absence of any reaction indicates impotent vaccine and necessity of revaccination.—H. M. GUILFORD, M. D., *Director, Division of Communicable Diseases.*

NOTICE TO PHYSICIANS

To help you impress upon the public the urgent necessity of smallpox vaccination and diphtheria immunization, a supply of the warning shown on the opposite page is being mailed to each general practitioner in the state, through the courtesy of the State Board of Health and your State Medical Society. Physicians desiring additional copies may have them by writing to either of the above in Madison, Wisconsin.

WARNING

Smallpox and Diphtheria Increasing!

Smallpox

Smallpox of a virulent type (sometimes called "black pox") has been introduced into the United States by members of the armed forces returning from the Orient.

There is a possibility that Army and Navy dischargees returning to Wisconsin may bring the disease here and spread it among unvaccinated persons.

You may recall a similar situation in 1925 when smallpox appeared in a neighboring state. Before it could be stopped there were 530 cases and 127 deaths in Wisconsin in a single year!

To prevent an outbreak of smallpox in Wisconsin the State Board of Health and the State Medical Society offer the following recommendations:

1. If you have not been vaccinated within the last five years, go to your family physician and get this protection NOW. Don't wait until smallpox appears in your community.
2. Don't make the mistake of thinking that your old vaccination scar is protection. A single vaccination may protect some persons for a lifetime but others are immune for only a short time. A *fresh* vaccination is your best protection—especially because of the virulence of the type of smallpox which has appeared in the United States.
3. Have your baby vaccinated early in life. Smallpox is especially likely to prove fatal to infants.
4. School children who have not been vaccinated within the last five years should be vaccinated NOW.

Diphtheria

Diphtheria is increasing in Wisconsin. Exposure to this great "child killer" may become greater as more and more military personnel return from Germany and other European countries where the disease is epidemic. These persons may act as carriers of diphtheria organisms without being ill themselves. Michigan and Minnesota have already had an increase of the disease. In Wisconsin twice as many cases have occurred this year as for the same months last year. Eight deaths have already occurred.

Immunization prevents diphtheria. Every child should have this protection. The following recommendations are made by the State Board of Health and the State Medical Society:

1. When your baby reaches the age of six months, take him to the family physician for the first diphtheria injection. A second injection should be given in four weeks to complete immunity.
2. A booster dose should be given when the child starts to school, to reinforce immunity which may have worn off.
3. Make sure that your child gets this protection NOW.

Vaccination Prevents Smallpox

Protect Yourself—Protect Your Children—Now!

Immunization Prevents Diphtheria

Protect Your Baby and Older Children—Now!

Wisconsin State Board of Health and the State Medical Society of Wisconsin

As It Looks From the AMA Council on Medical Service and Public Relations

Wisconsin is but one of many state, area, or specialty medical societies. Its perspective is that of a mid-western state. But its problems, at least in part, are also problems elsewhere. These pages are provided periodically for the reactions of medical leadership in other parts of the country.

I have been asked to write something for this column in regard to the job of the Council on Medical Service and Public Relations. Having been told that "the sky is the limit" and I might write about anything I wanted, I will try my level best to turn out something that may be of interest to Journal readers.

1. The first and principal job at this time of the Council on Medical Service and Public Relations and of medical organization from top to bottom is to get enrollment in the prepayment medical care plans as rapidly as possible.

2. It does look from where I sit in the bleachers way out in Chicago and Indiana as if the Wagner–Murray–Dingell bill will not pass at this session of Congress.

3. This is a "break" for it will give the medical profession an opportunity to establish medical care plans in those states where none exist and to correlate efforts and expand the coverage in those states where prepayment health insurance now exists.

4. The American medical profession is committed to voluntary health insurance as opposed to politically managed compulsory sickness insurance. Three to four million in medical care plans; twenty million in Blue Cross, forty million covered by health and accident policies are not enough. A great majority of the American people must be covered. This places a great responsibility on medical organization throughout the nation.

5. Time is of the essence. The task, though a great one, must be done as rapidly and as thoroughly as possible.

6. It is essential to cover the farm group. Most of the farmers are opposed to compulsory health insurance. The Farm Bureau Federation has passed a resolution favoring the voluntary method; the Grange is working in cooperation with California Medical Service, and plans are in the making for a cooperative effort in other states. However, unless methods are developed to cover those who live in rural areas with health and hospital insurance, we cannot always be assured of that support.

7. Proponents of compulsory health insurance maintain that the growth of voluntary plans has not been fast enough. They are wrong in this for actually voluntary prepayment plans have just made a good start. The growth in the number of plans since 1939 has been far greater than in the first few years of the Blue Cross.

Number of plans 1939	4 plans
Total plans in 1940	10 plans
Total plans in 1945	37 plans

Ten new plans already have been added to this in the first four months of 1946. Plans are now operating in twenty-eight states, with eight states in the process of organization.

In short—

Prepayment is the by-word
Cooperation the key
100 per cent enrollment the goal.

Working together—

The job can be done
The job must be done
The job *will* be done.

—Tom Hendricks.

Physicians in Service

For many months material in this section was carried under the title of "The Nation at War." With physicians still entering service, with many returning to reestablish themselves in civilian practice, and with many planning to continue in service for an indefinite time, it is the decision of the *Journal* to continue the section under a more timely title.

Military Notes

New Streptomycin Allocation Program to Make Provision For Civilian Uses

The Army Medical Department, which has received many requests for supplies of streptomycin to be used in treating civilian cases, has announced that all civilian inquiries and requests for this drug are to be sent to Dr. Chester S. Keefer, Evans Memorial Hospital, 65 East Newton, Boston, Massachusetts. Telephone Kenmore 9200.

Doctor Keefer is Chairman of the Committee on Chemotherapeutic and Other Agents of the Division of Medical Sciences, National Research Council, and has been authorized to handle civilian requests, providing they are submitted by a physician giving sufficient technical information to enable him to decide whether streptomycin is indicated in the treatment of the case.

Distribution of limited supplies of streptomycin to civilians has been provided for in the allocation program recently established by the Civilian Production Administration. Other agencies receiving allotments of the scarce drug include the Army, Navy, Veterans Administration, and the United States Public Health Service.

Although there has been a general misconception that the Army controls the total streptomycin supply, actually an approximate 30 per cent will be allotted to the Army from the production for the month of March. The bulk of the limited supply received by the Army has been employed in treating urinary tract infections associated with spinal cord injuries, and a few serious infections which have proved resistant to penicillin. At no time has the allotment been adequate to permit any extensive research, such as experimental work on the treating of tuberculosis. In order that Doctor Keefer may obtain an adequate supply for civilian appeals, the Army has voluntarily agreed to a delay in its March delivery of streptomycin from producers.

Grants-in-aid of approximately $500,000 for the clinical study of streptomycin, contributed in equal shares to the National Research Council by eleven pharmaceutical manufacturers, have already been announced by the Chemical Division of the Civilian Production Administration. The participating firms constitute the Streptomycin Producers Advisory Committee of the CPA.

Doctor Keefer, who headed the clinical investigation of penicillin, will be in charge of the similar program on streptomycin and will submit recommendations, together with a report on the results. The CPA has announced that there will be no commercial distribution of streptomycin at this time, nor will the producers supply the drug directly for civilian requests. Physicians have been asked not to submit requests for streptomycin if the cases are susceptible to the action of the sulfonamides, penicillin, and other therapeutic agents.

The production of streptomycin, which was approximately 3,000 grams last September, is expected to increase to nearly 27,000 grams by March. A companion drug to penicillin, streptomycin is produced in a similar manner, by fermentation and chemical extraction, and, like penicillin, requires carefully controlled conditions of temperature, air, and sterility. It is expected to prove a valuable supplement in cases where infections do not respond to penicillin treatment, but studies have not yet advanced to the point where the methods of administration or the amenable diseases are definitely known.

Army Program Prevents Importing of Disease

There is little or no risk of introducing foreign disease into the United States through returning military personnel from abroad, according to an announcement by the Office of The Surgeon General, which pointed out that the most careful estimates anticipate only moderate danger in a few cases.

This conclusion was reached after a world-wide survey by the Interdepartmental Quarantine Commission, which was jointly established by the Secretaries of War and Navy and the Administrator of the Federal Security Administration to study this problem.

With the end of the war and return of the bulk of combat forces, it is now possible to review actual results on a preliminary basis. Though tentative, highly optimistic conclusions appear warranted, the announcement stated.

To date no acute outbreak or secondary spread of an imported disease has been reported. While more slowly evident diseases may be identified later, it should be remembered that the traffic of war has gone on for four years, giving ample time for discovery of such diseases.

The 440,000 hospitalizations for malaria reported among Army personnel during the war fall short of pessimistic predictions for what has proved to be the most common infectious disease of troops abroad.

Even with the consideration that a portion of infected persons are liable to recurrence after their return to the States, conditions in this country are generally unfavorable for the spread of malaria and the chances of community risk are very small.

The special danger of cholera, smallpox, plague, epidemic typhus, and yellow fever is a matter of historical record. Immunizations were employed against all these diseases by the Armed Forces along with water purification, environmental sanitation, and disinfestation and insect control. This preventive medicine program was exercised even under combat conditions and its effectiveness was shown by Army records. The high general level of sanitation, insect control, and alert medical care available here forms the final link in the protection of this country from imported diseases.

The risk of importing disease from abroad has been less in some respects than in normal prewar traffic and the credit for these results has been attributed to the modern preventive medicine program of the Army and Navy.

Cases of exotic disease did occur, the announcement stated, but extensive investigation of likely hazards and critical application of preventive and corrective measures were effective in reducing risks to small proportions.

Lieutenant Colonel Theodore J. Pfeffer, Racine, is now Chief of Radiology Service at Letterman General Hospital in San Francisco. In London when the war ended, Colonel Pfeffer was transferred to Brigham City, Utah, before being sent to his present station. Doctor Pfeffer was radiologist at St. Mary's Hospital in Racine prior to entering the service July 23, 1942.

H. A. E. WENGER

Captain Harold A. E. Wenger of Madison is now doing anaesthesia work at Wakeman General Hospital, Camp Atterbury, Indiana. He went overseas in July, 1944, and returned to the states in August, 1945.

Captain Elmer P. Rohde of Merrill is now serving as medical officer at the Alaska Air Depot, Elmendorf Field. Having secondary duties as doctor for the Land Rescue Unit, he recently went to Point Hope, a little Eskimo village, to take care of a crew sent there to salvage a wrecked C–47 transport plane. He was to help them adjust to cold weather living. Upon his arrival the doctor was called upon to prevent an epidemic of diphtheria among the natives, and also gave emergency treatment for cases of chicken pox and acute tonsilitis.

First Lieutenant Robert G. Wochos is stationed in the American Zone of Occupation in Frankfurt, Germany, with the Headquarters Squadron of the 466th Air Service Group. He entered the Army in July, 1945, following the completion of his internship, and was ordered for duty at Foster General Hospital in Jackson, Mississippi. From there he went to Carlisle Barracks, Pennsylvania, and to the Air Service Hospital at Myrtle Beach, South Carolina, before going overseas.

Returning Veterans

Lieutenant Gordon E. Carroll of Laona was released from active duty with the Navy May 2, having served since May 2, 1943. He was stationed at Norman, Oklahoma, until August, 1943, when he was sent to the USS Ajax, a large fleet repair ship. There he served as Junior Medical Officer for eighteen months and as Senior Medical Officer for six months. His ship served in the Marshalls, Carolines, Gilberts, Leyte, and Okinawa with the 3d and 5th Fleets.

Lieutenant Carroll was stationed at Great Lakes for about two months previous to his discharge. He wears the Asiatic-Pacific Theater and Philippine Liberation ribbons.

Lieutenant Colonel E. F. Cummings, Oshkosh, received his discharge from the Army June 3. He entered the service in September, 1942, and was assigned to the Station Hospital at Fort Riley, Kansas. Later, the doctor served at the Winter General Hospital in Topeka, Kansas, and the Fitzsimons General Hospital in Denver. Doctor Cummings wears the American theater ribbon and has a unit citation.

Captain Kenneth D. L. Hannan, who is now practicing in Baraboo, received his discharge from the Army Medical Corps February 26. He was practicing in Prairie du Sac at the time of his entry into service, March 17, 1941.

Captain Hannan served with the 102d Medical Regiment at Fort McClellan, Alabama; Headquarters, Hawaiian Department, Fort Shafter, Hawaii; Medical Battalion Cadre, Camp Beale, California, and with the 45th Tank Battalion there; the 323d

Medical Battalion in Hawaii; and the 204th General Hospital in Hawaii and Guam. He wears the Asiatic-Pacific Theater ribbon with a battle star for the Marianas campaign.

Major Charles K. Kincaid, Eau Claire, was discharged from the Army Medical Corps February 10. He had been in service since January 1, 1943, serving with the 388th Engineering Regiment in Canada, the United States, England, and France; the 48th General Hospital in Marseilles; the 450th General Dispensary in Marseilles and Vienna; and the 605th Engineer Combat Battalion in Austria, and the United States. Major Kincaid wears the European Theater ribbon with two battle stars.

CHARLES E. KOEPP

Captain Charles E. Koepp is back in Marinette following his discharge from the Army Medical Corps December 29, 1945. He entered the service January 6, 1941, and served with the 5th Medical Battalion at Fort Custer, Michigan, before joining the 53d Medical Battalion, serving with it in Louisiana, Ireland, England, France, Luxembourg, Belgium, Germany, and Czechoslovakia. Captain Koepp wears the European Theater ribbon with five campaign stars, the Bronze Star Medal with an Oak Leaf Cluster, the Purple Heart, and the Meritorious Service Patch.

Lieutenant Theodore J. Kroyer, Walworth physician, has returned to practice after his discharge from the Navy February 11. He entered the service December 15, 1943.

A physician and surgeon in Beloit for two years before entering the Navy July 3, 1942, **Lieutenant Commander William J. Mauermann** has reopened his practice there. He was officially discharged March 15.

Commander Mauermann was stationed at Great Lakes; the Naval Training School in Dearborn, Michigan; Amphibious Training Bases in Little Creek, Virginia, and Galveston, Texas; with the LSM Group IV Staff in the Pacific; Surgical Team No. 18 in the Pacific; and Fleet Hospital No. 114 on Samar in the Philippines. He wears the Asiatic-Pacific and the Philippine Liberation ribbons.

Commander Adolph M. Hutter of Fond du Lac was released from active duty with the Navy March 28. His terminal leave ends May 16. Commander Hutter went on active duty March 28, 1943, and served at the Naval Hospital at Bethesda, Maryland, until December, 1944. He subsequently served at the U. S. Fleet Hospital No. 113 and the U. S. Naval Receiving Hospital, both at San Francisco. He went to Great Lakes in January, 1946, where he remained until his separation from service.

Commander Hutter, who wears the American Areas campaign ribbon, received the National Order of Honor and Merit from the Republic of Haiti in September, 1945.

Lieutenant Commander Frederick G. Jensen has returned to practice in Menasha. He was discharged from the Navy Medical Corps February 2, having served since June 28, 1943.

Commander Jensen served at the San Diego Marine Corps Base, the Naval Mobile Hospital No. 3 on Samoa, an Aviation Repair Unit on Guadalcanal, and the U. S. Naval Fleet Hospital No. 105 at New Caledonia. Returning to the states, he was stationed at Great Lakes from October, 1945, until his discharge. He wears the Pacific Theater ribbon.

Captain Clifford H. Kalb, former Grafton practitioner, is now in Milwaukee. He was discharged from the Army January 20, having served as allergist on medical service at Bruns General Hospital, Santa Fe, New Mexico, and with the 249th General Hospital in the Southwest Pacific. Captain Kalb entered the service November 18, 1942, and wears the Southwest Pacific Theater ribbon.

Major John J. Saxe of Portage went on inactive duty from the Army March 20, having served since August, 1943. He went on maneuvers with the 30th Infantry Division in Tennessee; with the 86th Replacement Battalion in England, France, Belgium, and Holland; and with the 82d Airborne Division in Holland, France, and Germany.

Major Saxe wears the European Theater ribbon with stars for the Normandy, Northern France, Ardennes, Rhineland, and Central Germany campaigns; the Combat Medic Badge; the Glider Badge; the Purple Heart; the Bronze Star; and the Belgian Fourragère.

Lieutenant Colonel Frank D. Weeks of Ashland received his discharge from the Army Medical Corps February 21. He had been in service since July 1, 1942. Colonel Weeks served at the Station Hospital, Fort Custer, Michigan; the Army Field Medical School, Carlisle Barracks, Pennsylvania; and the 44th General Hospital at Fort Sill, Oklahoma, Australia, New Guinea, and Leyte in the Philippines. He wears the Asiatic-Pacific Theater ribbon with two stars, the Philippine Liberation ribbon with one star, and a unit citation for the 44th General Hospital.

Major Robert A. Frisch of Milwaukee, who entered the Army July 15, 1941, received his discharge April 18, and has returned to practice. He served at Induction Stations in Milwaukee, Peoria,

and Chicago; Station Hospital, Fort Custer, Michigan; Percy Jones General Hospital in Battle Creek; and with the 126th General Hospital on Leyte in the Philippines.

Captain John W. Guepe of Milwaukee was discharged from the Army Medical Corps April 17. He had been in military service since November 9, 1942. His record of service includes: M. D. R. B., Camp Robinson, Arkansas; 897th Field Artillery Battalion, Fort Leonard Wood, Missouri; and the 221st Airborne Medical Company in New Guinea, Leyte, Luzon, and Japan. He wears the Asiatic-Pacific Theater ribbon with three stars and an arrowhead, the Philippine Liberation ribbon, and the Bronze Star Medal.

N. J. BARNSTEIN

Major Norman J. Barnstein, who has been at home in New Holstein on terminal leave, will open his medical practice there soon. Before enlisting in the Army in February, 1942, Doctor Barnstein operated the branch office of the Jackson Clinic in Sun Prairie. His terminal leave expires May 9.

Lieutenant M. Alex Krembs, former Chicago physician, has opened offices in Milwaukee. He was discharged from the Navy January 29, having served since August 6, 1943.

Lieutenant Krembs served at the San Diego Naval Air Station; the Naval Hospital at Shoemaker, California; with the 7th Amphibious Force on LST 22 and on Naval Beach Parties; and at the Hutchinson, Kansas, Naval Air Station. He wears the Asiatic-Pacific Theater ribbon with four stars, the Philippine Liberation ribbon with two stars, and the Silver Star Award.

Captain Raymond F. Kuhlmann, a resident at Columbia Hospital, Milwaukee, when he entered service August 11, 1941, was discharged from the Army January 24. He is now in orthopedic residence at Harvard Medical School.

Captain Kuhlmann was stationed with the 135th Medical Regiment at Camp Shelby, Mississippi; the 358th Station Hospital, Aruba, Netherlands West Indies; and the Deshon General Hospital, Butler, Pennsylvania.

Receiving his discharge from the Navy March 21, **Lieutenant Commander Albert H. Lahmann** has resumed his medical practice in Milwaukee. He entered the service May 15, 1944, and was stationed at the Family Hospital of the Naval Air Station at San Diego. Commander Lahmann then went on duty as senior medical officer on the USS John Land, AP 167. He wears the Asiatic-Pacific Theater and Philippine Liberation ribbons.

In service since January, 1944, **Captain Alvin G. Seelman** of Milwaukee received his discharge from the Army Medical Corps January 12, and has returned to practice. He served with the Medical Detachment of the 310th Infantry Regiment, 78th Division, at Camp Pickett, Virginia, and the ETO. He wears the European Theater ribbon with stars for the Ardennes, Rhineland, and Central Europe campaigns, and the Bronze Star Medal.

Lieutenant Commander Raymond H. Smits has returned to practice in West Allis. He received his discharge from the Navy March 8.

Commander Smits entered the service in November, 1943, and was stationed at Great Lakes and at the Amphibious Training Base, Camp Allen, Norfolk, Virginia, before going on sea duty. He served on LST 266 with the 12th Atlantic Fleet; LST Flotilla 18; at the Advanced Amphibious Base, Manadon Field Dispensary, Plymouth, England; Amphibious Receiving Base, Vicarage Barracks, Plymouth; Amphibious Training Base at Fort Pierce, Florida; and at Great Lakes until his discharge. He wears the African-European Theater ribbon.

Commander Gamber F. Tegtmeyer of Milwaukee has resumed his medical practice there, having received his discharge from the Navy March 23. Entering the service October 4, 1943, he first was stationed at Great Lakes; he then served at naval hospitals at San Pedro, Banning, and Treasure Island, California. He served six and one-half months at sea on the USS General C. C. Ballow (AP–157). Commander Tegtmeyer wears the African-European and China-Burma-India Theater ribbons.

Major Abe Adland of Milwaukee is now taking a postgraduate course in internal medicine at the University of Wisconsin Medical School. He will be officially discharged May 24. Major Adland entered active duty with the Army December 1, 1941, and spent twenty-one months overseas. He was stationed at Scott Field, and Camp Ellis, Illinois, before going to New Guinea with the 334th Station Hospital, serving at Milne Bay and Hollandia. Upon his return he was stationed at Billings General Hospital, Fort Benjamin Harrison, Indiana.

Major Adland wears the Asiatic-Pacific Theater ribbon with a star for the New Guinea campaign, and a Unit Meritorious Service Award.

L. R. WEINSHEL

Lieutenant Colonel Leo R. Weinshel has returned to Milwaukee County Hospital, following his discharge from the Army February 8. He was stationed with the 29th Division at Fort Mead, Maryland; in the Military District of Washington, D. C.; and at the AAF Station Hospital, Moody Field, Georgia, before going overseas. In September, 1944, he went to the European Theater of Operations with the 132d Evacuation Hospital and was subsequently transferred to the 67th Evacuation Hospital.

Colonel Weinshel wears the European-Asiatic-Mediterranean Theater ribbon with battle stars for the Rhineland and Central Europe Campaigns, and a Meritorious Unit Award.

Discharged from the Navy May 2, **Lieutenant Commander Howard M. Klopf** of Milwaukee has resumed his practice. He went on active duty at the Naval Hospital in Chelsea, Massachusetts, April 20, 1942. He then served as Medical Officer aboard the USS Upshur until August, 1943. He was subsequently stationed at the Receiving Barracks, Shoemaker, California; Puget Sound Navy Yard, Bremerton, Washington; and the Astoria, Oregon, Naval Station. He went on inactive duty February 16.

D. C. BEEBE

Commander Dewitt C. Beebe has returned to his office in the Sparta Clinic following his release from active duty with the Navy. While in the service Commander Beebe served as Medical Officer at a refueling and ammunition base at Sand Bay in the Aleutians, and as surgeon and Chief of Urology at a naval hospital on Attu. After returning from overseas duty, he was stationed at the Separation Center at Great Lakes. Commander Beebe entered the service January 24, 1944.

Lieutenant William P. Hamilton has returned to Dodgeville to resume his medical practice, following his recent discharge from the Navy. Lieutenant Hamilton entered the service February 14, 1944, and was stationed for two years in a hospital in England.

Dr. Hervey W. Dietrich, who formerly practiced medicine in Madison, has been separated from service with the Army Medical Corps and is now practicing in El Paso, Texas.

Lieutenant Commander Cecil R. Gilbertsen, on terminal leave from the Navy until May 28, has resumed his residence in Janesville. Commander Gilbertsen, who was commissioned in the Navy in August of 1943, spent eighteen months in the Pacific area in charge of medical work with a PT Repair Unit.

Drs. Lawrence W. Gregory and **Raymond S. Simenson** have opened an office in Manitowoc. Returning from service late last year, both doctors took postgraduate and refresher courses before resuming their practice.

Doctor Gregory spent two weeks at the Mayo Clinic and three months at Cook County Hospital in refresher courses, following his release from service December 10. Doctor Simenson spent four months in a postgraduate course at the University of Wisconsin, specializing in internal medicine and obstetrics. He was discharged December 29.

Major Lloyd F. Kaiser, former Rhinelander physician, has been released from active duty with the Army and will practice medicine in Champaign, Illinois. Major Kaiser joined the Army January 27, 1941, and served in the Hawaiian Islands and on Iwo Jima.

Lieutenant Commander Richard A. Jensen, Menasha, has returned to practice there. He was recently discharged from service, after spending nineteen months in the South Pacific. He was attached to the surgical staff of Advanced Base Hospital No. 6 in the New Hebrides; ship's surgeon aboard an assault transport which participated in D-day landings on Guam and the Marianas; and was stationed at Great Lakes following his return to the states. Commander Jensen entered the service September 24, 1942.

Lieutenant Colonel Frederick G. Hidde, released from service January 25, has opened an office in Sheboygan in partnership with **Major Reed M. Simpson,** formerly of St. Louis. Colonel Hidde joined the Wisconsin 135th Medical Regiment in January, 1941, serving at Camp Shelby, Mississippi, Australia, and New Guinea. He returned to the United States in January, 1945, and was assigned as staff surgeon at Camp Macy, Texas. Major Simpson was discharged March 7, having served at an air base north of Hudson Bay, and in orthopedic service at Madigan General Hospital, Fort Lewis, Washington.

After serving forty-one months in the Army, **Dr. Roger T. Thompson** is opening an office in Superior. Doctor Thompson served as Chief of the Eye Department in Army General Hospital No. 23 in the Africa, Italy, France, and Germany campaigns.

Lieutenant Colonel Walter Philippe Manning, Army Medical Corps, of Mellen, was officially reported as "killed in action" on January 9, 1945, while a prisoner aboard a Japanese prison ship enroute from Manila to Japan.

Colonel Manning was graduated from the University of Minnesota Medical School and interned at the Minneapolis General Hospital. He was commissioned a first lieutenant in the Medical Reserve of the Army on June 13, 1931, and immediately went on active duty with the Civilian Conservation Corps. He was commissioned a first lieutenant in the Regular Army Medical Corps September 1, 1935. He graduated from the Army Medical School in 1936 and from the Army Medical Field Service School in 1937.

Colonel Manning was assigned to duty at Fort Hamilton, Brooklyn, until December, 1939, when he went to the Philippines. While there he served at Nichols Field and Sternberg General Hospital. At the outbreak of war Colonel Manning was serving as assistant to the Surgeon of the Philippine Department. He was promoted to the grade of major in December, 1941, and to the grade of lieutenant colonel very shortly thereafter.

Colonel Manning served with troops in the defense of the Philippines, Bataan, and Corregidor where he was taken prisoner when the American Forces surrendered. He was imprisoned at Bilibid Prison in Manila and later at Cabanatuan Prison Camp. On December 13, 1944, Colonel Manning, along with several hundred other American prisoners, boarded a Japanese prison ship destined for Japan. This ship was bombed and sunk in Subic Bay, P. I., on December 15. He swam ashore from the sinking ship and aided in the rescue of other prisoners. After a week the prisoners were loaded aboard another prison ship enroute to Japan. While entering a harbor on the west coast of Formosa (Taiwan), the second ship was bombed and Colonel Manning was killed instantly by shell fragments. His remains are interred on the island of Formosa.

Colonel Manning received the Distinguished Service Medal for unusual ability exhibited in the planning and organization of Regular Army medical field units, and for his training of personnel for medical service in the Philippine Army. He was awarded the Bronze Star Medal for "fearlessly exposing himself to bombing and strafing in order to give aid to wounded prisoners from the prison ship that was sunk in Subic Bay." He was awarded the Purple Heart for wounds received "in action."

Colonel Manning is survived by his wife and parents, Mr. and Mrs. Albert Manning, of Mellen, Wisconsin.

HARRY VANDER KAMP

Lieutenant Commander Harry Vander Kamp has returned to Baraboo to resume his practice in association with **Dr. C. R. Pearson.** Entering the Navy March 20, 1944, he served chiefly in the Pacific Theater. Commander Vander Kamp wears a battle star for the Okinawa campaign.

Three members of the Midelfart Clinic in Eau Claire have returned from service: **Lieutenant Colonel Peter Midelfart,** general surgery; **Commander Samuel L. Henke,** dermatology; and **Lieutenant Commander Charles M. Ihle,** orthopedics. **Lieutenant (j. g.) John H. Wishart,** now on duty with the Navy, is expected to return soon. Colonel Midelfart, in the Army more than three years, served in Australia, New Guinea, and the Philippines. Commander Henke served in the Navy for more than two years, and was stationed at Farragut, Idaho; San Bruno and Shoemaker, California; and Oahu, Hawaii. Commander Ihle served with a mobile unit on various Pacific Islands and in China; he was in the Navy over three years.

Two new members of the clinic staff are also returned servicemen: **Major R. L. Kennedy,** urologist; and **Major A. W. Hilker,** internal medicine. Major Kennedy served four and one-half years with the Army in the Caribbean area. Major Hilker was in the Army four and one-half years, serving with evacuation and general hospitals in England, France, Belgium, and Germany.

H. W. KISHPAUGH

Recently separated from active duty with the Navy, **Lieutenant Commander Harold W. Kishpaugh** resumed his medical practice in Beloit April 1. Receiving his commission in November, 1943, Commander Kishpaugh served twenty-seven months, nineteen of them in the Pacific theater as Senior Medical Officer of a combat transport.

On terminal leave until May 20, **Lieutenant Colonel Howard J. Lee** is joining the faculty of Marquette University and will engage in practice with **Dr. Theodore L. Squier**. Entering the Army September 2, 1942, he served as chief of the general medical section of Fort Leonard Wood, Missouri, for a year; chief of medical service at Winter General Hospital, Topeka, Kansas; chief of medical service at the Camp Carson General Hospital, Colorado Springs, Colorado, from June, 1945, until January 1, 1946, at which time he became Commanding Officer. He was detached from the service February 20.

Former Lake Mills physician, **Lieutenant Commander Edgar A. Schoenecker** has been released from active duty with the Navy and is resuming his medical practice. Commander Schoenecker served a year in New Guinea and the Philippines.

Major Harry L. Schwartz, in the Army since August 1, 1942, has returned to Kenosha and his medical practice. He wears the European Theater ribbon with five battle stars, the Purple Heart, the Soldier's Medal, and a Presidential Citation.

Captain John J. Simones, eye, ear, nose, and throat specialist, has returned to La Crosse following more than thirty-two months in the Army in that work. He was stationed at Army hospitals at Lakeland Army Air Field, Florida; Alexandria Army Air Field, Louisiana; and Bolling Field, Washington, D. C.

D. M. BRITTON

Major Donald M. Britton, Madison, now on terminal leave after nearly four years with the Army Medical Corps, has resumed his medical practice, and is now associated with **Drs. H. F. Haney** and **J. P. Malec**. Major Britton entered the Army July 21, 1942.

Lieutenant Commander Harry Mannis has resumed his practice in Sparta. Following his discharge from the Navy, Commander Mannis took postgraduate work at the Wisconsin General Hospital.

Doctor Mannis entered active duty with the Navy June 21, 1944.

Recent Releases From Service*

Physicians and Location	Date Discharged
Adland, Abe, Milwaukee	May, 1946
Baker, V. L., Milwaukee	May, 1946
Birk, B. J., Milwaukee	April, 1946
Brown, R. J., Milwaukee	February, 1946
Brukardt, H. R., Milwaukee	March, 1946
Buckley, C. H., Menomonie	March, 1946
Burpee, G. F., Edgerton	April, 1946
Burzynski, E. E., Watertown	April, 1946
Callan, R. E., Milwaukee	December, 1945
Carroll, G. E., Laona	May, 1946
Davee, Chalmer, River Falls	March, 1946
Davis, M. D., Milton	May, 1946
Dawson, D. L., Rice Lake	February, 1946
Dean, Frank K., Madison	May, 1946
French, G. A., Appleton	February, 1946
Frisch, R. A., Milwaukee	April, 1946
Gearhart, R. S., Madison	May, 1946
Guepe, J. W., Milwaukee	April, 1946
Gulbrandsen, H., Viroqua	May, 1946
Haukohl, R. S., Milwaukee	March, 1946
Heller, T. A., Milwaukee	March, 1946
Henske, W. C., Chippewa Falls	May, 1946
Hill, F. A., Plymouth	May, 1946
Hitz, J. B., Milwaukee	January, 1946
Hutter, A. M., Fond du Lac	May, 1946
Irwin, W. G., Lodi	January, 1946
Kalb, C. H., Grafton	January, 1946
Klopf, H. M., Bonduel	May, 1946
Koepp, C. E., Marinette	December, 1945
Krembs, M. A., Milwaukee	January, 1946
Kronzer, J. J., Oshkosh	March, 1946
Kuhlmann, R. F., Milwaukee	January, 1946
Lemmer, K. E., Madison	April, 1946
Mitchell, M. T., Eau Claire	January, 1946
Nickelsen, J. R., Racine	December, 1945
O'Neill, J. W., La Crosse	March, 1946
Parke, George, Jr., Richland Center	April, 1946
Peckham, B. M., Milwaukee	March, 1946
Reibold, F. W., Superior	December, 1945
Rife, C. S., Milwaukee	December, 1945
Rikkers, D. F., Milwaukee	April, 1946
Schiek, I. E., Jr., Rhinelander	February, 1946
Swanson, R. F., Milwaukee	May, 1946
Tegtmeyer, G. F., Milwaukee	March, 1946
Thanos, J. N., Milwaukee	February, 1946
Walske, B. R., Independence	March, 1946
Welbourne, R. P., West Allis	February, 1946
Werner, D. J., Milwaukee	April, 1946
Wier, J. S., Fond du Lac	February, 1946
Winkler, R. J., Hilbert	December, 1945
Winters, K. J., Wauwatosa	May, 1946
Worm, George, Milwaukee	January, 1946
Young, J. J., Appleton	January, 1946

* Members of the State Society listed in boldface.

VETERAN PHYSICIANS' EXCHANGE

This page will be devoted to a classified section, open without charge to: (a) veteran members desiring location and (b) other members having professional openings suitable for men returning from military service.

LOCATIONS WANTED

DESIRE GENERAL PRACTICE in town 5,000–25,000 anywhere in Wisconsin with good hospital facilities. Have much of own medical equipment from previous general practice. Over 3 years service in U. S. Public Health Service with wide variety of general practice especially in internal medicine, general surgery, psychiatry, and eye work, especially refractions. Must have housing for wife and three children. Would consider partnership with older doctor who does own general surgery. Would also consider joining clinic. Address No. 112 in care of the Journal.

LOCATION WANTED: I have had a limited experience in general surgery, internship and residency. Experience as surgeon in native hospital while in service. Desire location with ample training facilities to enable eventual board application, assisting reputable surgeon, or general practice with surgical opportunity. Address No. 122 in care of the Journal.

ASSOCIATION WANTED: Veteran physician with 4½ years postgraduate training, primarily in surgery, in excellent institutions, having completed 5 years active naval service, intending to take the examinations for the American Board of Surgery, desires an association with an established group or surgeon. Will appear for personal interview promptly. Address No. 124 in care of the Journal.

ASSISTANCE WANTED

LOCUM TENENS WANTED: A capable physician desires locum tenens for a short or long period. Will not compete afterwards. Licensed in Wisconsin. References furnished. Address No. 125 in care of the Journal.

SUBURBAN PRACTICE: Unusual opportunities in La Crosse. Office space available and help in contacts. See ad on page 458 for details.

DOCTOR WANTED: The doctor who practiced here for over 50 years recently died. There is a modern house, water, bath, etc.; excellent double garage, can be heated; office attached to house, small waiting room and small drug room, no modern equipment. Good will of the community goes with opportunity. Address No. 114 in care of the Journal.

ASSOCIATE DESIRED: To do internal medicine and pediatrics. Also required to assist in major surgery. Excellent opportunity in a good community which has a well-equipped 60-bed hospital. Applicants must have had postgraduate training in internal medicine or pediatrics. Address No. 115 in care of the Journal.

ASSISTANT WANTED: Recent graduate or discharged medical officer, preferably single, protestant, and particularly interested in going general practice in prosperous small town. Present gross income over $20,000 and more work available than can be handled satisfactorily by one active doctor since recent additions of factories, etc. Hospital connections nearby; housing facilities at present only drawback. Address No. 123 in care of the Journal.

VETERAN PHYSICIANS: This is a strategic time to enter public health. State Board of Health has 2 openings for physicians with executive ability as directors of the tuberculosis and venereal disease divisions. Salary $4,800 to $5,400 plus necessary traveling expenses, Madison headquarters. 5 district health officers also needed. If you were under 40 when entering the armed services and can otherwise qualify, write Dr. Carl N. Neupert, State Health Officer, Madison 2, Wisconsin.

WANTED: Staff physician at sanatorium approved for tuberculosis residency. Beginning salary $250–$300, less modest maintenance deduction. One position open July 1, another probable the last of March. Wisconsin licensure required. Person must have good professional and personal qualities. Write Superintendent, Wisconsin State Sanatorium, Statesan, Wisconsin.

For additional classified advertisements, see the Physicians' Exchange, page 562

F. J. POHLE

U. OF W. TEACHERS SHARE CLINIC SPOTLIGHT

Drs. Frederick J. Pohl (left) and John E. Gonce, Jr. will participate in the 1946 Clinics. Doctor Pohle will discuss the "Diagnosis and Treatment of Hepatic Disorders," while Doctor Gonce will present a paper on "Meningitis in Children." Both will present dry clinics in the afternoon and discuss antibiotics, along with Doctors Womack and Keettel.

J. E. GONCE

Minutes of the Council, Milwaukee, January 26 and 27, 1946

1. Call to Order

The Council was called to order by Chairman S. E. Gavin, Fond du Lac, at the University Club, Milwaukee, at 7:00 p. m., Saturday, January 26.

2. Roll Call

Councilors present were Doctors Wilkinson, Pechous, Vingom, Heidner, Gavin, Beebe, Nadeau, Christofferson, Arveson, Ekblad, Witte, Fitzgerald, Blumenthal, Leahy, and Past-President Fidler.

Also present were President Minahan; President-Elect Dawson; Treasurer Sisk; Speaker Cary; Doctor Neupert, state health officer; Doctor Supernaw, member of the Council on Medical Service and Public Relations; Secretary Crownhart; and Assistant Secretary Ragatz.

3. Approval of Minutes of Meetings

Upon motion of Councilors Blumenthal–Vingom, the minutes of the meetings held in May, June, September, and October, 1945, were approved unanimously.

4. Introduction of New Council Members

Doctor Witte of Milwaukee and Doctor Wilkinson of Oconomowoc, new members of the Council, were introduced by Chairman Gavin.

5. Councilor District Reports

Chairman Gavin called upon the individual councilors to make their reports as to conditions in their respective districts in accordance with Section 2, Chapter VI of the By-Laws.

First District

Doctor Wilkinson, as the new councilor for the First District, reported that because he had assumed his duties so recently, he was unable to present an extensive report on conditions in his district.

Second District

Doctor Pechous, Kenosha, stated that the active membership in his district, composed of Racine, Walworth, and Kenosha counties, had been low during the war but that the doctors were slowly returning from service and the maximum membership was expected in the near future. A district meeting was held during the year at which Dr. Charles Fidler of Milwaukee, at that time president of the State Society, and Mr. Charles Crownhart, secretary, spoke.

The industrial health program at the Snap-on Tool Corporation is progressing very well, the company is well satisfied with the work the physicians are doing, and the project has been reported in various publications.

Walworth County, at a meeting in Delavan, indicated its support to the Wisconsin Plan. Both Racine and Kenosha counties were recorded against the plan.

Third District

Doctor Vingom, Madison, reported that the condition of the profession in his district was very good.

He attended a meeting at Rock County at which Dr. E. R. Schmidt and Dr. Anthony Curreri were present, and in addition, attended the Third Councilor District meeting held at Madison in the fall, at which 150 members were present. The district meeting was held in honor of Dr. W. S. Middleton, dean of the University of Wisconsin Medical School, who recently returned from military service.

Doctor Vingom stated that the hospital situation in his area was unfavorable due to a limited number of beds.

A majority of physicians in the Third District have signed up to participate in the Wisconsin Plan, and Doctor Vingom stressed the importance of extending coverage in any insurance plan.

Fourth District

As Doctor Spiegelberg, Boscobel, was absent, a report for the Fourth Councilor District was not made.

Fifth District

Doctor Heidner, West Bend, stated that a councilor district meeting was not held during the year, but it was expected that one would be held in the spring. Physicians are returning from military service, and the shortage of physicians in the district is being corrected.

The Wisconsin Plan was accepted by the Manitowoc and Washington–Ozaukee societies, but no report was available on Sheboygan or Calumet counties.

Sixth District

Chairman Gavin reported an active membership in his district of 238 doctors, excluding service members. Thirty-eight have not returned from service, and twenty doctors have returned. Attendance at meetings was excellent during the year, and the members have shown a keen interest in both the sessions and the chance to meet with their fellow practitioners.

A councilor district meeting was held at Oshkosh at which Dr. Loyal Davis of Chicago was the speaker of the evening. Doctor Gavin stated that attendance at this meeting was the largest it ever had been.

Practically the entire district had indicated support to the Wisconsin Plan, with Fond du Lac, Outagamie, and Winnebago counties signed up almost 100 per cent, to date.

Seventh District

Doctor Beebe, Sparta, stated that seven counties comprise his district—Trempealeau, Jackson, Buffalo, La Crosse, Vernon, Juneau, and Monroe. Out

of a total district membership of 100, over half reside in the city of La Crosse. The oldest member is 82, the youngest 34. Five members are over 75, eighteen over 70, twenty-four over 65, thirty over 60, fifty over 55, thirty are in their 40's, and ten in their 30's.

There are eleven hospitals in the district. One at Whitehall, Black River Falls, Arcadia, Mauston, Hillsboro, Viroqua, Sparta; and four at La Crosse. In the southern area, Vernon County, of which Viroqua is the county seat, adequate hospitalization is not provided. Plans are under way for enlarging the hospital program in this section.

Out of a total membership in the district of 100, Doctor Beebe met and visited with sixty. He attended one meeting of the Trempealeau–Jackson–Buffalo society held at Black River Falls. This society was organized over twenty-five years ago and has functioned on a high level since that date. Their programs are excellent.

The La Crosse society invites the councilor to each of its monthly meetings, and Doctor Beebe reported he had attended at least six La Crosse meetings during the year. Programs were excellent.

The annual meeting of the district was held at Sparta and was well attended. Speakers were Major W. C. Fenske of Chippewa Falls and Dr. Arnold Jackson of Madison.

Two deaths were reported, those of Dr. William Trowbridge of Viroqua and Dr. Jens Rosholt of La Crosse.

Eighth District

Doctor Nadeau, Marinette, reported that the district consists of Marinette–Florence, Oconto and Shawano county societies and that each county has a well-functioning society with the exception of Florence which is attached to Marinette. The first district meeting held by the Eighth District in many years was attended by about sixty physicians, and the group was addressed by the president of the Society and Dr. W. D. Stovall of Madison.

A meeting was held also for a discussion of the Wisconsin Plan, and talks were presented by a spokesman for the Milwaukee Surgical Care plan and by Secretary Crownhart. Following this session, the cities of Marinette and Peshtigo signed up 100 per cent for the Wisconsin Plan.

Service men are returning to active practice. The district suffered one casualty, that of Doctor Tousignant who was lost on a prisoner ship when it was sunk.

Hospital facilities in the district are well organized at Shawano in Oconto County and at Marinette which has an eighty-six bed hospital. Doctor Nadeau felt the Marinette hospital was one of the finest in the state and welcomed any county planning to expand or increase its facilities to visit the Marinette hospital.

Professional relations in the district were reported as excellent.

Ninth District

Doctor Christofferson, Colby, reported that his district consists of Lincoln, Marathon, Clark, Green Lake–Waushara, Portage, Waupaca, and Wood county societies. The district had four scientific sessions during the year and speakers were secured from Chicago, Madison, Rochester, and the Twin Cities.

The last district meeting was held at Marshfield, and attendance was the largest it ever had been. The Wisconsin Plan was discussed, and practically 100 per cent of the physicians in the district signed up to participate.

The shortage of physicians in Clark County has been acute as only 50 per cent of those who normally practice in the county are in practice at the present time. Population of the county, on the other hand, has increased ten to fifteen thousand since Doctor Christofferson started his practice there forty-four years ago.

Tenth District

Doctor Arveson, Frederic, reported that conditions in his district were satisfactory.

Eleventh District

Doctor Ekblad, Superior, stated that a district meeting was held during the summer and that scientific sessions had improved. Bayfield County reported one death, Dr. Fred Johnson, Sr. Ashland County reported all its men back from service, and in Douglas County all but two have returned.

Douglas County held ten meetings during the year, all scientific sessions. Three members of this society passed away during the year—Doctors Snell, Mason, and Kyllo. Douglas County had signed up 100 per cent for the Wisconsin Plan.

Twelfth District

Doctor Blumenthal, Milwaukee, stated that each councilor was sent a copy of "Medical Progress in 1945" and had been placed on the mailing list to receive the "Milwaukee Medical Times."

About 120 of the 300 members who were in military service have returned to civilian practice. Refresher courses have been established in all of the local hospitals, as listed in the January issue of the Medical Times. A roster of returned members has been published and will be kept up to date as the doctors are separated from service.

The Physicians Service Bureau has transferred many emergency calls to the recently returned doctors, thus assisting the veteran to get back into practice. The January issue of the Medical Times was a "Veteran's Issue," with much of its space devoted to matters of particular interest to the veteran doctor.

The cancer detection center has examined nearly 1,300 cases in less than eight months. Some of the other public health activities in the district were the orthoptic clinic which has been most helpful in eye muscle training, the Milwaukee Rehabilitation Service, and the Hard of Hearing Clinic.

A recent examination of the records of Surgical Care indicated that the plan was being properly and well supervised and conducted. As the Milwaukee County Society had endorsed the Surgical Care plan, Doctor Blumenthal felt that the county society would not support the Wisconsin Plan enthusiastically.

Hospitals in the district are full. County meetings of the society are well attended with about 250 to 300 at the scientific sessions.

Doctor Fitzgerald, Milwaukee, reported that the hospital situation in the county was serious because of the extreme shortage of beds, and that the records of the Procurement and Assignment Service showed that 140 doctors have returned to Milwaukee County and that eighty-five doctors have moved in from outside in the state. One hundred and fifty doctors were still in service. Two hundred and eighty-seven doctors entered service from civilian practice, and any others were either residents or interns.

Doctor Witte, Milwaukee, stated that the Milwaukee County membership felt that the insurance plan developed by the Committee on Extension of Insurance was misrepresented to the House of Delegates, that the resolution approved by the Council of the Society provided that "a proper committee of this Society be instructed to confer with licensed insurance companies in this state in an effort to secure the extension of sickness care policies to a point as to provide the broadest comprehensive coverage possible within a premium structure that particularly appeals to the so-called low income group." He added that the Milwaukee members believed that the authorization provided by this resolution was only for the committee to confer with the insurance companies to see if they could enlarge policies already existing and did not commit the Society to the adoption of an insurance company program, as was stated to the House of Delegates.

He stated that the Milwaukee membership wondered why he was not permitted to make a report on the subject for the Committee on Medical Economics and Voluntary Sickness Insurance of which he was chairman. In addition, he stated that the Milwaukee doctors wondered why the House of Delegates elected Doctor Fitzgerald when the county society delegates had selected himself as their nominee to succeed Doctor Eberbach as councilor.

The county society membership also wondered why Doctor Witte should be criticized for his reference to some insurance salesmen and stated that the Milwaukee members do not feel that they have proportional representation in the House of Delegates or the Council.

Thirteenth District

Doctor Leahy, Park Falls, reported that his district consisted of Oneida–Vilas, Langlade, Forest and Price–Taylor county societies. No district meeting was held in the district since the start of the war. Oneida–Vilas has held regular meetings as has Langlade. Forest County held three meetings at Laona during the year.

The Price–Taylor Farm Security Administration insurance plan is in its second year of operation. A few adjustments were made at the end of the first year, and the plan worked out very successfully in the first year of operation.

Delegates from the Thirteenth District voted in favor of the Wisconsin Plan at the October meeting of the House of Delegates, with the exception of one.

All of the physicians in service from the district have returned to practice in their respective communities.

Past-President's Report

Doctor Fidler, Milwaukee, stated that he looked forward to the meetings and the chance to discuss problems of the Society with the men he had worked with during his term of office as president.

President's Report

Doctor Minahan, Green Bay, stated that he had only one objective during his term of office, that of establishing good fellowship throughout the state. He declared that matters involving policy should be discussed in an orderly manner.

Upon motion of Councilors Witte–Vingom, carried unanimously, the secretary was instructed to provide each councilor with a copy of the remarks that he had made on the conditions in his councilor district. This was followed by discussion of questions raised through the councilor district reports, but no action was taken or proposed.

Doctor Witte questioned the legality of election of councilors at the House of Delegates meeting. Chairman Gavin pointed out that his point was not well taken as he was confusing the Council with the House of Delegates, and this matter could not be appealed to the Council. Doctor Witte appealed the decision of the chair to the Council, and on the question of whether the decision be sustained, the vote was recorded as follows:

District	Councilor	Aye	No	Not Voting	Absent
First	Wilkinson	X	--	--	--
Second	Pechous	X	-	--	--
Third	Vingom	X	--	--	--
Fourth	Spiegelberg	--	-	--	X
Fifth	Heidner	--	X		--
Sixth	Gavin	X	--	--	-
Seventh	Beebe	--	X	--	-
Eighth	Nadeau	X	--	--	-
Ninth	Christofferson	X	-	--	
Tenth	Arveson	-	--	-	X
Eleventh	Ekblad	X	-	-	-
Twelfth	Witte	--	X	--	--
	Fitzgerald	--	--	X	-
	Blumenthal	--	-	X	--
Thirteenth	Leahy	--	-	X	
Past-President	Fidler	--	--	X	-
		7	3	4	2

The result was a vote of seven to three in favor of the decision of the chair with two members absent and four not voting.

The meeting recessed at 10:30 p. m. until Sunday morning, January 27.

SUNDAY, JANUARY 27

All members present at the session the previous evening were in attendance at the Sunday morning session which convened at 9:15.

6. State Board of Medical Examiners

Chairman Gavin called upon Dr. C. A. Dawson, secretary of the State Board of Medical Examiners, to present a report on the activities of his board. Doctor Dawson said that since the last meeting of the Council in October, about 127 applicants had been examined by the board.

7. State Board of Health

Doctor Neupert, state health officer, reported that between monthly meetings of the board, material that is to be taken up by the group is sent to the members. This material is sent out at least once a week. He stated that cooperation with the secretary's office of the State Medical Society had been invaluable in many instances.

He stressed the importance of physicians throughout the state reporting cases of communicable diseases so that accurate studies may be made. At present there are nine district health offices, with another to be set up. Of the nine, there are five vacancies with only four district health officers to handle the work for all of the districts. Only two of the four have special public health training, and the other two physicians are waiting for an opportunity to acquire this training. The board is anxious to secure younger men for the positions open in the other districts.

Doctor Neupert stated that smaller districts were needed and reviewed the discussion presented at the House of Delegates in October on this matter.

In the communicable disease picture, there are three outstanding problems. One is poliomyelitis, of which there were 600 cases during the year, the second largest number in history. The virulent types of diphtheria found in Europe, particularly in Poland, are returning to this country. The incidence of venereal disease has risen, and reports have been coming in more satisfactorily since the Council appointed its Special Committee on Venereal Diseases to urge that these reports be made promptly. There were only sixteen cases of smallpox in the state during the year, and if vaccination is continued, the disease will be wiped out. Preventive medicine was stressed throughout.

Enlarged laboratory facilities are needed, and in this connection, Doctor Neupert stated that Wisconsin is way behind its neighboring states of Michigan, Minnesota and Illinois which have much better facilities.

With consent of the Council, Chairman Gavin instructed the secretary to incorporate in the record an expression of appreciation to Doctor Neupert in behalf of the Council for his complete report on the activities of the State Board of Health.

8. Council Committees

Secretary Crownhart was asked by Chairman Gavin to outline the problem with regard to Council committees. It was pointed out that some of these committees had reported direct to the House of Delegates and others to the Council. Secondly, it was suggested that the Committee on War Participation be dropped as an active committee inasmuch as its duties had been completed.

Following discussion, it was moved by Councilors Heidner–Arveson that the Council committees should report direct to the Council rather than to the House of Delegates, and the motion was carried unanimously.

In addition, upon motion of Councilor Christofferson–Past-President Fidler all Council committees were continued with the exception of the Committee on War Participation, and the motion was carried unanimously.

9. Election of Officers for 1946

Chairman Gavin turned the gavel over to President Minahan with the request that he conduct the election of officers.

Upon motion of Councilors Arveson–Pechous, Dr. S. E. Gavin was nominated to succeed himself as chairman of the Council. No further nominations being made, the secretary was instructed to cast the unanimous ballot of the Council for Doctor Gavin, upon motion of Councilors Ekblad–Nadeau, and the motion was carried unanimously.

Upon motion of Councilors Fitzgerald–Nadeau, Dr. I. R. Sisk was nominated to succeed himself as treasurer of the Society and of the Council. No further nominations being made, the secretary was instructed by unanimous vote to cast the ballot for Doctor Sisk.

Upon motion of Councilors Ekblad—Heidner, Mr. C. H. Crownhart was nominated to succeed himself as secretary of the Council and of the Society. No further nomination being made, the ballot was declared closed and the unanimous ballot of the Council was cast for Mr. Crownhart.

10. Report of the Treasurer

Doctor Sisk, treasurer, presented the following report for the year 1945:

REPORT OF DR. IRA R. SISK, TREASURER
For the Year Ended December 31, 1945

Cash on Deposit—First National Bank, January 1, 1945		$ 35,777.23
Revenues		
Membership Dues	$ 65,184.65	
1945 Exhibit Space Rentals	1,800.00	
Proceeds from securities called	7,330.00	
Gains on sale of securities	145.00	
Interest Received	1,574.11	
Principal collected on Aetna Insurance policy	1,004.40	
Checks issued in 1944 cancelled and restored in 1945	1,150.00	
Industrial Clinic Receipts	1,329.65	
Total Revenues		79,517.81
Total		$ 115,295.04

Expenditures		
Constitutional Officers and Committees		
President's Travel	$ 500.00	
Council and Committees	3,924.52	
Books and Periodicals	248.10	
Delegates to A. M. A.	300.00	
Auxiliary	100.00	
Secretary's Salary	9,000.00	
Secretary's Travel	1,173.42	
Group Total	$ 15,246.04	
Staff		
Assistant Secretary's Salary	$ 4,500.00	
Assistant Secretary's Travel	217.97	
Secretarial Staff Salaries	8,153.22	
Executive Assistant to the Secretary	1,295.00	
Group Total	$ 14,166.19	
Administrative Expenses		
Accounting and Insurance	$ 941.06	
Social Security Taxes	583.12	
Rent	1,800.00	
Telephone and Telegraph	1,393.23	
Supplies and Light	974.68	
Postage and Printing	2,667.99	
Fixtures and Upkeep	293.79	
Miscellaneous	1,247.90	
Group Total	$ 9,901.77	
Totals—carried forward	$ 39,314.00	$ 115,295.04
Membership—Special Service		
Legal	$ 1,795.77	
Special Bulletins to Members	637.23	
Blue Book Issue	750.00	
Hygeia	277.50	
Lay Publications	240.04	
Bulletins to Members	808.95	
Telephone and Telegraph	842.18	
Services, general counsel	1,500.00	
Voluntary Sickness Insurance Trials	5,533.47	
Group Total	$ 12,385.14	
Public, Industrial and Agricultural Health and Public Instruction		
Rent of Office	$ 660.00	
Preparation of Panel	456.99	
Administrative Assistant	1,995.00	
Industrial Clinics and County Programs	2,372.34	
Printing	1,145.43	
Assistant, Public Relations	1,538.73	
Publications	325.48	
Press Releases	534.00	
Radio and Special Releases	944.22	
Group Total	$ 9,972.19	
Annual Meeting, Postgraduate Centers, and Wisconsin Medical Journal		
House of Delegates Meeting	$ 1,532.02	
Postgraduate Centers	None	
Wisconsin Medical Journal	2,600.00	
Group Total	$ 4,132.02	
Other Expenditures		
U. S. Government Bonds purchased	$ 10,000.00	
1945 Exhibit Space Rental returned to Exhibitors	3,875.00	
Group Total	$ 13,875.00	
Total Expenditures		79,678.35
Cash on Deposit—First National Bank, December 31, 1945		$ 35,616.69

Allocation of Cash Balance at December 31, 1945 by Funds:	
Fund "A"—General Operating	$ 18,870.14
Fund "B"—Public, Industrial, and Agricultural Health and Public Instruction	13,022.46
Fund "C"—Annual Meeting, Postgraduate Centers and Wisconsin Medical Journal	4,222.13
Fund "D"—Investment Cash (Overdraft)	(498.04)
Total Fund Balances, December 31, 1945	$ 35,616.69

Securities Owned December 31, 1945

Description	Interest Rate	Maturity Date	Face Value	Cost
U. S. Government				
U. S. Savings Defense, Series G	2½	6-1-53	$ 2,000.00	$ 2,000.00
U. S. Savings Defense, Series G	2½	6-1-54	6,000.00	6,000.00
U. S. War Savings, Ser. G	2½	9-1-54	3,000.00	3,000.00
U. S. War Savings, Ser. G	2½	6-1-55	5,000.00	5,000.00
U. S. War Savings, Ser. G	2½	1-1-56	8,000.00	8,000.00
U. S. War Savings, Ser. G	2½	8-1-56	5,000.00	5,000.00
U. S. Treasury	2½	9-15 67-72	3,000.00	3,000.00
U. S. Treasury	2½	12-15-72	10,000.00	10,000.00
Total U. S. Gov't			$42,000.00	$42,000.00
Public Utilities				
Milwaukee Gas Light Co.	4½	3-1-67	$ 1,000.00	$ 1,057.50
Milwaukee Gas Light Co.	4½	3-1-67	2,000.00	2,000.00
Southern California Edison Co. Ltd.	3	9-1-65	2,000.00	2,080.00
Wisconsin Gas & Electric Co.	3½	4-1-66	1,000.00	1,030.00
Wisconsin Power & Light Co., Series A	3¼	8-1-71	3,000.00	3,206.25
Total Public Utilities			$ 9,000.00	$ 9,373.75
Total Securities Owned, Dec. 31, 1945			$51,000.00	$51,373.75

Upon motion of Councilors Arveson–Christofferson, the treasurer's report was accepted unanimously.

11. Interim Report of the Secretary

The interim report of the secretary was presented as follows:

With the submission of this report to the annual meeting of the Council, the secretary concludes four years in that position, all of which time he has served as secretary in a professional organization which has suffered, with the nation, a great World War. The time for "reconversion" is at hand, but this report deals not in anticipation so much as it deals with an accounting for the year which has just ended.

It is difficult for your secretary to present his interim report in divisions classified into office activities, for the central office of the State Medical Society is one developed to serve the varied needs of the profession. The office involves scientific and economic activities, and in all of them it is charged with the function of representing the physicians as a whole rather than any one segment or geographic area.

At the outset, the secretary must express his deep personal appreciation to the councilors and officers for their willingness to consult with the office on any occasion and who give so much to the objectives of the State Medical Society. The secretary wishes to acknowledge also the cooperative spirit of an able and conscientious office staff who seem to have absorbed by proximity the devotion to duty which is one of the outstanding characteristics of the profession they serve.

Membership

On the basis of the last pre-war normal year, slightly over 2,400 fully paid members of the State Medical Society were listed. At the end of 1945, there were 1,977 fully paid members against 2,004 in 1944, and against the 2,000 anticipated a year ago. While there are some numbers of physicians now returning from service, under action by the Council in 1945, dues are waived until six months following the actual date of their release from service.

It is difficult to estimate just what the fully paid membership will total at the end of 1946, but perhaps it will total in the neighborhood of 2,200, with a gradual increase each subsequent year until the Society, in the first normal post-war year, should number approximately 2,500 and perhaps 2,600 fully paid members, with an additional group falling in the classification of resident or affiliate members.

MEMBERSHIP—JANUARY 9, 1946

1. Fully paid members	1,952
2. Partially paid members	0
3. Members in service paying no dues in 1945	514
4. Members in service paying prorata dues in 1945	22
5. Members in service who have not yet reported date of induction	0
6. War members who pay no dues	114
7. Resident members who pay $3	22
8. Life, honorary members, members whose dues were waived because of temporary but serious incapacity	67
	2,691
Delinquents	21

The Wisconsin Medical Journal

The tentative balance sheet and profit and loss statement for *The Wisconsin Medical Journal* for the year 1945 follows below this section of the report. It is believed to be self-explanatory; but in commenting on *The Wisconsin Medical Journal* generally, the secretary desires to emphasize that its editing and its preparation are not a simple task.

It is probably unnecessary to remind the councilors and officers that the scientific articles, following approval by the medical editor, are edited in this office for grammatical correctness, with citations verified through the facilities of the Medical Library. Following the setting in type of these articles, author's proof is submitted; and whatever corrections are incorporated from that source are shown in the final publication.

While advertising has been particularly satisfactory, in some measure due to gasoline rationing and manpower shortages, many of the advertisements occupy preferred locations in the *Journal;* and remittance is based upon those advertisements appearing in the identical location specified in the contract. Anywhere from half a dozen to a dozen advertisements are carried in color, and the color is not the choice of the *Journal* but the choice of the advertiser.

These two matters alone are more complicated than would appear on the surface, as the actual putting together of the *Journal* is somewhat akin to starting out a jigsaw puzzle with certain of the pieces initially placed in spot locations. If the *Journal* finds it possible to run two advertisements in the same color on the same sheet of paper, it means a saving in publication cost of upward of $30; and it may, therefore, be appreciated with what attention to detail and planning the *Journal* ultimately reaches the desk of the membership in Wisconsin.

It was not long ago that the *Journal* editorial policy consisted of a half-page comment on current activities of the profession; but through the encouragement of the Council on Medical Service and Public Relations a more vigorous editorial policy has been adopted. Editorials on scientific medical matters are solicited from physicians in Wisconsin whose professional attainments constitute them an able source of authority. It has been the practice to secure a review of editorials on these subjects through one or more officers of the Society as well as through the medical editor, and occasionally through non-official sources.

Editorials pertaining to medical economics are prepared upon subjects suggested by the membership or on which there is no doubt of current interest. These again are reviewed by one or more officers of the Society whose interests and activities in the profession place them in an adequate position to review proposed subjects objectively. Thus, editorials dealing with the subject matter which may be within the jurisdiction of some committee of the Society, are frequently referred to the chairman of that committee, while others may be referred to individual practitioners in the state or elsewhere for their reactions prior to publication.

Nor is the preparation of an editorial a simple matter. It must be written to be expressive of medical opinion generally, and it must be written with accuracy and careful attention to detail. As an editorial, it has value only if it stimulates reader interest and sizes up a matter of current concern.

Again, largely at the suggestion of the Council on Medical Service and Public Relations, a policy has been established in the *Medical Journal* to solicit guest editorials from those whose contributions would be of interest to the profession and the laity alike. No other Journal in the country is following a policy comparable to that in Wisconsin. But certainly it may be said of the Wisconsin *Journal* that its guest editorial policy has been such as to open its columns to all sides of various questions involved in medical economics today.

Other matters have likewise been incorporated in the *Journal* within the past year. One is the inclusion of a monthly comment from the State Board of Health, while another is the presentation of a comment from some other state organization or specialty society whose views would be of interest to the membership. Aside from other miscellaneous format changes, as well as editorial improvements,

the *Journal* now incorporates the Medical Forum, a magazine within the magazine. The Forum offers several distinct advantages. The character of type and the column size permit the publication in eight pages of a volume of material that would require almost twice as much space were regular *Journal* page style to be used. It permits the inclusion within one section of the *Journal* of practically all the material that otherwise would be distributed without emphasis throughout the entire *Journal.*

The Forum has been developed to reflect national trends and state trends as well. Many of its articles are original contributions from within the Society's staff. It has received favorable comment from many who have had an opportunity to review it.

All this is to the point of stating that the *Journal* requires a very considerable amount of managerial supervision as well as actual editing. In 1940, it was possible to publish *The Wisconsin Medical Journal* with the assistance of one full-time employee, utilizing perhaps four or five days each month from a Society employee in assisting in proofreading. Under present arrangements, while the *Journal* account carries the salary of one employee, another employee devotes fully half to three-quarters of her time to purely mechanical procedures of the *Journal;* and the increased managerial responsibilities, both in preparation and publication, require considerably more time from the secretary and the assistant secretary.

However that may be, it appears that the *Journal* shows the increased attention given to it and is demonstrating the value of an effective house organ within the ranks of the profession of this state.

In concluding a comment upon the *Medical Journal,* your secretary cannot refrain from discussing again the point that no advertisement is carried of products within the jurisdiction of any of the councilors of the American Medical Association if their advertising is not acceptable to those councils. It is unfortunate that the *Journal* in Wisconsin must have some competition from publications that do not adhere to the same high standards; but it seems apparent that an official publication of the State Medical Society must stand shoulder to shoulder with its parent organization, the American Medical Association, in permitting advertisement both in the *Journal* and through the annual meeting of only those products that meet the standards that the profession nationally has deemed advisable and in the interest of public health. Such has been the position of this Council since the acquiring of *The Wisconsin Medical Journal* in 1910, and it is the position that has been reiterated on subsequent occasions, the last being through the advice of the special Advertising Committee authorized by the Council in 1945.

THE WISCONSIN MEDICAL JOURNAL
Madison, Wisconsin

TENTATIVE BALANCE SHEET
December 31, 1945

Assets		
American Exchange Bank		$ 9,774.30
Accounts Receivable—Advertisers		821.57
Postage Deposit		96.16
Copyright Deposit		6.00
Mailing Envelopes Inventory		214.83
Office Equipment	$ 243.75	
Less: Allowance for Depreciation	216.42	27.33
Total Assets		$10,940.19
Liabilities, Reserves, and Surplus		
Current Liabilities		$ None
Reserve for Blue Book Issue		750.00
Surplus, January 1, 1945	$ 7,295.09	
Add: Net Income for the year	2,905.10	
Surplus, December 31, 1945		10,190.19
Total Liabilities, Reserves, and Surplus		$10,940.19

TENTATIVE INCOME AND PROFIT AND LOSS STATEMENT
For the Year Ended December 31, 1945

Income		
Advertising		$18,408.61
Subscriptions, Supplements, etc.		245.31
Miscellaneous		8.00
Total Publication Income		$18,661.92
Expenses		
Printing	$13,446.83	
Salaries	2,055.00	
Cuts	1,169.04	
Mailing	606.89	
Rent	540.00	
Miscellaneous Expense	31.68	
Supplies	43.75	
Discounts Allowed	140.66	
Accounting Service	240.00	
Editorial Expense	50.00	
Social Security Tax	20.55	
Depreciation on Office Equipment	12.42	
Total Publication Expenses		$18,356.82
Publication Profit		305.10
Add: State Medical Society Appropriation		2,600.00
Net Income for the year		$ 2,905.10

1946

There has been a willingness on the part of individual members of the secretarial staff to shoulder added burdens during this wartime period regardless of personal sacrifice or inconvenience involved, but many of those activities, it is now apparent, are not emergency ones but rather involve a long-time, carefully developed program of the profession in this state as well as nationally. In some measure, at least, the 1946 recommended budget plans a moderate reorganization of the secretary's staff to permit the more expeditious handling of some of these matters. The decision involves no substantial added budget expenditures but a reshifting of activities and a deliberate planning of other activities as an eighteen-month event rather than an annual event.

The publication of the panels under the Workmen's Compensation Act is a program that, it is suggested, can be utilized on an eighteen-month basis after the publication of a new panel in 1946,

thus permitting a lowered annual budgeting for this activity. This is an illustration of some procedures that it is felt can be utilized in an effort to provide the secretary's office with implementation toward handling the increased burdens that have developed from *The Wisconsin Medical Journal*, medical care insurance, industrial health activities, public health and educational activities, advertising problems of the *Medical Journal* and the annual meeting, and the increased activity on the part of certain committees whose active participation in public health matters is a foregone conclusion if the profession is to have a part in shaping its own future development.

The secretary urges councilors to review the proposed budget in detail prior to the meeting of the Council so that they may be prepared to offer any suggestions on the basis of a preliminary study.

In this connection, the secretary desires to remark on an outstanding policy of the State Medical Society. *The Wisconsin Medical Journal* has been characterized in this report as a house organ of medicine. As such it has carefully portrayed to the membership an accounting of the activities of its major committees, its Council, its officers and its employees. The budget upon which its affairs are predicated for a given year is printed in the same detail in which it is considered by the Council itself. Through its news items, through the issues immediately preceding the sessions of the House of Delegates and by special bulletins to members, the policy of the State Medical Society has been at all times to provide its membership at large with the details of the activities of the Society.

A most cordial invitation is extended to Society members to visit the Madison office whenever possible, not for the purpose of a social call but for the purpose, as a co-owner and as a co-operator, to view the office in its detail of operation.

Scientific Work

With all the attention devoted to economic and organizational problems of the Society, it is not forgotten that scientific work constitutes the background of the Society structure. The *Journal* has already been a subject of comment in this report. The spring clinics will be increasingly active in 1946, and in this year it will be possible to resume the scientific sessions in connection with the annual meeting. These and a multitude of other activities indicate the Society's true objective in effort to preserve a certain amount of unimpeded economic enterprise and its effort to preserve its continued scientific achievements in public health.

In Conclusion

The secretary desires particularly to emphasize that while an official of the State Medical Society, he construes his obligation to the profession and to the officers who are accountable for his election, to serve the profession as they shall command. It is his responsibility, as he reviews it, to submit to the membership and to its official bodies factual material pro and con on the many matters which are of Society concern, and, upon their ultimate judgment, to carry out in a procedural sense the substantive judgment of the profession.

It is a source of concern to him that on occasion official determinations of the Society may be voided through action other than the orderly process provided by the House of Delegates or the Council of the State Medical Society. While there must always be room for diversity of opinion within an organization that is truly democratic, yet the will of the majority constitutes the true governing spirit which makes for sound organization devoted to a public cause. In an organization that is truly democratic, positions taken in error or, in light of hindsight, in the failure of the exercise of sound judgment, will always be subject to change. But the interest of those who sought the establishment of that position or who have helped formulate the policies of the profession must never be regarded as other than selfless and for the good of the Society as a whole.

In 1945, your secretary commented upon some of these problems, and to close desires to reiterate statements made at that time:

"At times though not always, your secretary has been concerned by what seems to be a growing addiction to judge the position of medicine solely by the field that lies ahead and not by the relative progress over a span even so narrow as that of twenty-five years.

"He is dismayed at times by the efforts of those who would destroy the authority that medicine has gained and the good that it proposes to do, through the promotion of the subtle rumor and the insinuating remark that never challenges but tends only to undermine. But there is reassurance in the thought that never before, in any time of stress, has medicine lost stature by these tactics—nor will it happen now so long as those who have the privilege to guide the policies of medicine hew firm to the line that the strength of a democratic organization lies in its faults as well as in its praiseworthy objectives and accomplishments—that those who only criticize in fact criticize themselves—that those who fail to accomplish their purposes within an organization are not worthy of recognition if they accept its decisions only in resentment and hurt.

"But medicine in its symbolic as well as concrete good to the sick and injured, the weak and the feeble, the young and the old, is too fine in itself to lose the spirit and objective that is the heritage of generations."

Respectfully submitted,

C. H. Crownhart.

Upon motion of Councilors Heidner–Leahy, the report of the secretary was accepted unanimously.

12. The 1946 Budget

The proposed budget was considered item by item; there was extensive discussion by those present, and each item was approved as follows:

The 1946 Budget

A. General Account

Constitutional Officers and Committees

1. *President*—An annual appropriation to the president to assist in travel, long-distance telephone and other expenses incidental to the office—begun in 1935 ..... $ 500
2. *Council and Committees*—Including unbudgeted committees and delegates to the American Medical Association. To simplify bookkeeping procedures, the secretary suggests that these accounts be combined in 1946. The normal anticipated cost of Council meetings and committee meetings is included in this appropriation together with appropriations for stationery and postage expense of councilors and committee members, such as the annual meeting chairmen who are called upon to do a considerable amount of correspondence. In addition, the sum includes a moderate amount for reimbursement of those physicians who are called upon and respond freely for discussions of medical care subjects. The delegates to the A. M. A. are provided railroad fare and hotel and meal expense within this appropriation as well, inasmuch as it has been the policy of the Society to recognize the fact that with four to five meetings of the House of Delegates in virtually continuous session, as well as meetings of various reference committees, delegates have little or no time to attend any of the scientific sessions at the annual meeting of the A. M. A.
   Each year there also arises some situation in which a wholly unanticipated expenditure is required to provide for the expense of committee activity. This account provides for this contingency as well 5,780
3. *Books and Periodicals*—Each year indicates the continued necessity of an appropriation to supply councilors and committee members with publications of importance in medical matters 200
4. *Auxiliary*—This has been an established appropriation for some years.. 100
5. *Secretary, Salary* 9,500
6. *Secretary, Travel*—The secretary is reimbursed for actual expenses in attendance at committee meetings, A. M. A sessions and conferences, and similar functions 1,275

Total—Constitutional Officers and Committees $17,355

Organization Staff

7. *Assistant Secretary, Salary* 5,000
8. *Assistant Secretary, Travel* 400
9. *Secretarial Staff*—In November, 1943, salary and job classifications were established in the office within which administrative discretion has been permitted in order to maintain a trained and capable staff. The Society's office has experienced during this period what is the experience of any office and that is a fairly rapid turnover of employees and a difficulty in securing trained replacement with the necessity, on occasion, of overlapping periods of training a new employee during the balance of tenure by the old employee. This appropriation would maintain present salary levels for one administrative assistant, the office manager, and two assistant stenographers. Councilors will wish to note item 33 in which provision is made for other assistance. It appears obvious that salary levels pertinent to this character of employment prior to 1941 no longer are applicable. Therefore, this appropriation also includes $600 for anticipated adjustments necessary during 1946 with the suggestion that this authority be extended the secretary as in other years 8,460

Total—Organization Staff $13,860

Administrative Expense

10. *Accounting and Insurance*—This item includes provision for the part-time services of our public accountant for the books of the secretary and treasurer, the cost of the annual audits, and the various insurances carried by the Society, such as fire, workmen's compensation and public liability 750
11. *Social Security Taxes*—The Society is subject to the social security laws and is complying with the Wisconsin Unemployment Compensation Law .. 335
12. *Office Rent*—The present quarters were secured with approval of the Council to reduce fire hazard to irreplaceable and invaluable records in an old building. The total rent of the offices of the State Medical Society and *The Wisconsin Medical Journal* is $3,000, the balance of $540 being paid out of the *Journal* fund, and $660 paid from account 32 1,800
13. *Telephone and Telegraph*—The amount allocated appears to be an absolute minimum in light of past experience 1,200
14. *Current Supplies and Light*—This item covers stencils, mimeograph paper, second sheets, typewriter ribbons and like items of normal office requirements, and office lighting 900
15. *Postage and Printing*—The printing referred to is essentially stationery. The postage bill of a normal outgoing mail of more than 100 pieces, first class per day, seems to be an irreducible item. In addition, this item covers the membership certificate mailing, correspondence and postage for our bulletins to committees and officers. While some economies have been effected, these are now offset by increased costs that are beyond our power to control 2,300

16. *Fixtures and Upkeep*—The Society finds it essential to purchase a file, and sometimes two, a year; to overhaul its typewriters; to provide for pairs of such devices as the addressograph, projectors, mimeograph, etc.; and like incidental expenses of normal upkeep ---------- 350

17. *Replacements and New Equipment*—When Society offices were expanded and when it housed employees furnished by Civilian Defense and the War Manpower Commission, the Society was faced with an insufficient amount of equipment, and at the same time an almost impossible buyer's market. As a result, several typewriters were borrowed as were several pieces of office equipment. This was thought to be a temporary situation, but the total employees of the Society now number ten as against eight in 1941 and consequently this equipment is permanently needed. During 1946 it will be necessary to return the borrowed equipment and to replace it.
In addition, the Society is confronted with the fact that it is using an old model, hand-operated mimeograph machine. While this is satisfactory up to a certain amount of production, the mimeograph machine is now used so consistently and delivers such a large volume of material that both because of its age and because of office problems, it is believed necessary to replace it with an up-to-date, electrically operated machine.
In addition, it is believed advisable to replace certain dictaphone equipment which is now so antiquated as to be virtually impractical of use. Adequate equipment of this character would help markedly in the stenographic situation in the office ---------- 1,750

18. *Miscellaneous*—In the statement of the budget figures above, the minimums have been used. Each year, however, finds us confronted with situations, emergency in their nature, requiring either a wholly new and unanticipated expense of over-the-budget expenditures. An example, for instance, will be a year when five bulletins to members, costing $600 instead of the budgeted $450, are required. This item is to permit a leeway to this limited extent. In addition, this fund supports temporary additional help ---------- 950

19. *Group Insurance*—For obvious reasons, it seems apparent that the Society should extend to its employees the opportunity for group insurance that is extended by other organizations. The total cost of health and accident insurance combined with moderate provisions for group life insurance would be in the neighborhood of $45 monthly, with the Society contributing the cost under arrangements to be perfected by approval of the Council ---------- 300

Total—Administrative Expense -- $10,635

Membership—Special Service

20. *Legal*—The State Society is frequently called upon by county societies to advise them as to membership rights and related questions. Occasional problems of emergency character are presented, such as that in 1941 when the Society appeared in the Supreme Court on the subject of expert witnesses. Officers of the Society themselves frequently must resort to legal counsel in order to safeguard the general policies of the Society, and further work carried on under this appropriation includes advice to members concerning problems which affect the profession at large, assistance in interpretation, and participation under various relief laws, analysis of other laws peculiarly affecting the profession of medicine, and compilation of the Blue Book material. Problems involving need for legal assistance are increasing in number ---------- 1,800

21. *Bulletins*—With a membership of 2,500, a single special bulletin to members costs $150, perhaps more in 1946. Experience of past years indicates annual requirement of at least four of these ---------- 600

22. *Blue Book*—This represents but the excess printing and mailing costs for this annual issue of the *Journal* which is continually revised and new material incorporated. The size of the Blue Book issue has been substantially increased, and reprints of special articles are in greater demand -- 750

Total — Membership — Special Service ---------- $3,150

Public Health—Normal Service

23. *Hygeia*—This is authorized as a standing appropriation to present at Christmas time, a year's subscription to all state officers, the nine state teachers' colleges and certain others who have to do with public health problems and procedures ---------- 300

24. *Lay Publications*—This represents the cost of furnishing health studies, documents and pamphlets to those who have to pass upon health procedures and proposals ---------- 200

25. *Bulletins to Members*—Cost of bulletins dealing with proposed changes in public health laws and rulings --- 500

26. *Special Reports in The Journal*—Supplements or insert sections dealing with state and national health problems ---------- 250

27. *Telephone and Telegraph*—Dealing with health legislation ---------- 400

28. *Legislative Counsel*—Services general counsel. These services include analyzing legislation to ascertain that dealing with health subjects, compilation of data concerning effect of proposed changes and discussions with official bodies. It is felt advisable to provide for an increase so as to have added help in this particular field. There are not only state matters to consider but matters involving the federal proposals as well ---------- 2,000

congestive heart failure

The de-edematizing action of Searle Aminophyllin decreases the cardiac burden, permitting the heart muscle to function more efficiently.

Searle Aminophyllin produces diuresis whether administered orally or parenterally, and thus has a field of usefulness covering emergencies and chronic congestive cardiac failure.

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ACCEPTED AMERICAN MEDICAL ASSN. Council on Pharmacy and Chemistry

SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

29. *Medical Care Insurance* ---------- 1,250

Total—Public Health—Normal Service ---------- $4,900

B. Public, Industrial and Rural Health, and Public Instruction

Note: The House of Delegates at the 1943 session raised dues $2 beyond the sum believed necessary to meet the possible loss over a per capita dues of $25 caused by the number of members in service upon whom no dues responsibility rests. This particular increase was designed to implement increased activity in public health education, and the same increase was continued at the 1944 and 1945 meeting. This budget item is to continue the program in 1946.

30. *Panel Preparation and Distribution*—Originally this activity was conceived as necessary at least once a year if not oftener, but anticipating difficulty in financing this program, the panels were distributed over a three-year period to hedge against possible income loss. It has been continued as an eighteen-month project for the time being, but V-Day requires early revision. It should be noted in this connection that approximately over 50,000 panels are distributed throughout Wisconsin, and their acceptance by employer groups is constantly increasing. The Wisconsin program has been viewed as one of exceptional success. It is estimated by responsible insurance authorities that 90 per cent of Wisconsin employees subject to the Workmen's Compensation Act make their physician choice, in event of need, from those listed on the open panel. Printing and assembling costs are somewhat higher and distribution more comprehensive than in earlier years ---------- 4,000

31. *Medical Procedures in Industry*—The promulgation of a model industrial health program supported by the various groups interested will doubtless be accomplished in 1946. Problems will involve not only examinations, but proper placement, the industrial nurse, follow-up activity and the like. There may be some activities pertaining to veteran and civilian rehabilitation ---------- 2,700

32. *Health and Public Instruction*—In recent years, this appropriation has covered the printing, paper and postage costs of furnishing a weekly story on health and its further attainments to weekly and daily papers of the state, and includes the radio program now carried on twelve stations in Wisconsin. In recent years, experimental efforts were made in the field of providing health exhibits at county and state fairs, and in the circulation of material particularly intended for lay consumption. The fair exhibits have met with wholly unanticipated success. It is estimated that over 10,000 visited the exhibit at the 1944 state fair. The appropriation suggested is to permit carrying on these basic procedures, as well as to expand them as a means of public health education, along the lines indicated by the House of Delegates in other years -------- 4,200

33. *Special Note; Executive Assistance.* The three preceding accounts have carried in past years an allocated amount of office rent and expenses. There has also been assigned to this budget the salaries involved for an administrative assistant, a secretarial assistant in part of the public relations program with one other classification of stenographic assistant, left vacant in 1945.

It now seems apparent that the full effect of the various matters within these appropriations cannot be carried out without more time given to the direction than is available from the secretary and assistant secretary. While the Council foresaw this situation in establishing a contingent fund in 1945, it was found that these various problems necessitate an understanding of the Society's views and this in turn indicates the advisability of an assistant who can freely circulate in medical meetings. The budget contains provision for this by a separate allocation for salary, travel, and miscellaneous expense ---------- 6,500

Total—Public, Industrial and Public Health, and Public Instruction $17,400

C. Scientific Medicine

35. *Annual Meeting*—This appropriation represents the cost to the Society over exhibit income for a normal year. In 1944 the unused balance in the postgraduate clinic account was used as a carryover to this account. It is suggested that this practice be continued. While exhibits for 1946 have been secured in greater volume than in any previous year, costs have also increased as to all activities. It seems indicated that as a victory meeting of the State Medical Society, some additional funds should be made available 2,200

36. *Postgraduate Clinics*—It will be these clinics and the extent to which they are carried to the membership that will point to the success of the Society's "refresher" program as to returning medical veterans ---------- 1,200

37. *Wisconsin Medical Journal*—The secretary "points with pride" to the financial report of the *Journal* incorporated in the interim report. There is nothing in the picture, however, to indicate that this is more than a temporary result. Every effort has been made to induce a greater volume of local advertising, and some progress has been made along those lines. However, the bulk of increased advertising comes through national advertising and this may not be continued with the war's ending. Publication of the *Journal* is an involved and difficult process. All members of the staff contribute, but even so the *Journal* has long outgrown the day when it could be edited by one full

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Infants and Children WITH PAPAYA FRUIT

DRIED FRESH TO PRESERVE NATURAL ENZYMES AND PECTINS

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THE LATEST ADDITION to the famous S. M. A. Infant Foods —CEROL . . . something new in infant feeding—FLAVORED . . . with mellow papaya fruit—FORTIFIED . . . with vitamins and minerals — READY TO SERVE . . . a nutritious, precooked, multigrain cereal—Supplied in 8 oz. packages.

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Prescribe Journal-advertised products and you prescribe the best.

time employee plus several days proofreading assistance from other members of the staff. As a matter of fact, the *Journal* deserves two full-time assistants. That is probably not now immediately possible.

In 1945, a new feature was added to the *Journal*, the Medical Forum. This has met with considerable success and has been a feature mentioned in many publications as indicating a worthwhile service on behalf of medical journals generally. Under present plans, eleven issues will be run. No Forum section occurs in the annual Blue Book issue of the *Journal*.

Exclusive of the clerical assistance involved, the Forum costs in the neighborhood of $1,200 a year. It has been sustained in 1945 largely as a result of increased advertising revenues, but it does not appear that these revenues will be available in 1946 to the same extent as in 1945. Efforts are now being made to see whether it will be possible to carry a sufficient amount of advertising in the Forum alone to carry at least part of its cost. It is believed that the Society should appropriate $50 monthly to the *Journal* in order to help in the publication of the Forum. It may be that in 1946 it will be possible to work out revenues by way of advertising in the Forum section that will remove its publication almost entirely from any expense to the Society, except for editorial work 3,200

Total—Scientific Medicine	$6,600
Total 1946 Budget	$73,900

13. Conference Committee on the Wisconsin Plan

The Council was advised that the Wisconsin Plan called for the organization of a Conference Committee to work with insurance carriers in executing details of the plan and its further perfection. The committee was to be composed of an equal number of representatives of the medical profession and of the insurance carriers, who would meet periodically to confer on problems that may develop. Pending Council approval, the Committee on Extension of Insurance had constituted itself the physician members of the Conference Committee and asked for recommendations of the Council.

Following discussion, it was moved by Councilors Witte–Blumenthal that approval be given to the action of the Committee on Extension of Insurance in constituting itself as the physician representation of the Conference Committee without implication of blanket approval to all actions of the Committee on Extension of Insurance. The motion was carried unanimously.

14. Committee on Veterans Programs Authorized

Chairman Gavin called upon Doctor Supernaw, chairman of the Subcommittee on Veterans of the Council on Medical Service and Public Relations, to present a report on the activities of his committee.

Doctor Supernaw stated that one of the most important questions which will confront the medical profession for the next several years will be that involving the establishment and operation of a suitable program to provide medical and health services for veterans of World War II. It is expected that Wisconsin will have more than 400,000 veterans to care for, and it was felt that the State Society should establish some means of cooperating with the Veterans Administration to provide this care.

Programs developed in various parts of the country were outlined for the consideration of the Council, and Doctor Supernaw recommended that a committee be appointed by the Council with power to establish a program in Wisconsin for this care and that the sum of $7,500 be authorized for the committee's expenditure in developing the program.

Following discussion, it was moved by Councilors Arveson–Pechous that a committee of three be appointed by the Council with the power to enter into an agreement with the Veterans Administration in establishing a veterans' care program, that funds be provided the committee up to a maximum of $7,500 for the development of such a program, and that such program be reported to the Executive Committee of the Council which in turn will make its recommendations to the Council as a whole. The motion was carried unanimously.

15. Dr. Joseph Evans Elected to Honorary Membership

Doctor Vingom was asked to present a report on the membership record of Dr. Joseph Evans of Madison and stated that Doctor Evans had been a member of the State Society for forty-five years, was recently elected to honorary membership in the county society, and because of his outstanding service to the medical profession in the state through his work at the University of Wisconsin, Doctor Vingom recommended that honorary membership in the State Society be granted.

Upon motion of Councilors Vingom–Blumenthal, Doctor Evans was elected to honorary membership in the State Society, and the motion was carried unanimously.

16. Program of Education on Alcoholism

Doctor Beebe moved that the Council suggest to the members of the Wisconsin State Board of Health the advisability of initiating a program of education relating to the causes and prevention of the disease known as "alcoholism" which presently claims from one to three million victims in the United States. The motion was seconded by Doctor Vingom and carried.

17. Advertising of an Institution for Treatment of Alcoholism

A summary was presented to the Council with regard to advertising of an institution treating alcoholism, and it was pointed out that despite the

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For Nervous Disorders

A fifty bed hospital and sanitarium. Separate buildings for neurotic and psychotic cases.

Illustrated booklet sent on request.

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HERBERT W. POWERS, M.D

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WITH THIS ONE

AO *Weymouth Ful-Vue*

You Can Fit All Crests

To simplify your fitting problems, to provide satisfaction for your patients, prescribe this 3-way adjustable frame.

With one Weymouth frame you can fit the variable crests of various patients because three special lens patterns automatically change the bridge from regular to high or low positions without alternating the bridge measure or disturbing correct eye position.

With AO Weymouth you have a zyl frame that provides a complete and ophthalmically precise fitting range.

Ask your AO Representative to demonstrate the advantages of the new AO Weymouth frame.

American Optical
COMPANY

LOW CREST
Obtained by using lens pattern S3-7L.

MEDIUM CREST
Obtained by using lens pattern S3-7.

HIGH CREST
Obtained by using lens pattern S3-7H.

Prescribe Journal-advertised products and you prescribe the best.

fact that local representatives of the profession had approved acceptance of this advertising, the reputation of the institution on a national basis was questionable.

Following discussion, it was moved by Councilors Vingom–Leahy that the American Medical Association should be advised of the State Society's findings on a local basis, and if, after that information was provided the A. M. A., it felt the advertising should be discontinued, the State Society should support its parent organization. The motion was carried unanimously.

18. Classified Advertising

A problem frequently presented to the *Journal* was the method of handling classified advertisements from non-members of the Society. It had been the practice to accept advertisements from members without charge and from non-members at $2 per inch for the initial advertisement and $1 per month thereafter.

Recently an advertisement was accepted for the sale of the practice of a non-member. A local physician advised that membership had been refused to this individual and questioned the wisdom of carrying such an advertisement.

This problem was referred to the Advertising Advisory Committee which suggested the following policy:

a. That advertising be restricted to members only as a service of membership. As long as such ads are restricted to one inch, no charge shall be made. Ads in excess shall cost $2 per inch in excess of the initial inch furnished free, for the first insertion, and $1 per insertion thereafter.

The same privilege shall be extended to widows of members in reference to sale of equipment and practice.

b. New licentiates (who have not had the opportunity of becoming members) shall have the privilege of advertising their desire for location at the established charges noted above.

c. Members in good standing in other states, desiring to advertise for locations in Wisconsin will be accorded the privilege of advertisng in the classified section of the *Journal* at the rates quoted above.

Upon motion of Councilors Christofferson–Leahy, the recommendations of the Advertising Advisory Committee were approved, and the motion was carried unanimously.

19. Committee on the Audit and the Budget

Upon motion of Councilors Blumenthal–Arveson, the Auditing Committee's name was changed to the Committee on the Audit and the Budget and the committee was enlarged to five members, with the provision that this committee shall conduct and certify an annual audit of the Society and shall carefully study, formulate and recommend an annual budget for the Society which shall then be presented to the Council for final consideration and approval. The motion was carried unanimously.

20. Report on National Physicians Committee Conference

Chairman Gavin and Doctor Supernaw presented a report on the recent conference of the National Physicians Committee at St. Louis, which they had attended, relative to the Wagner–Murray–Dingell legislation. The meeting was called for the purposes of providing representatives from each state with authentic information on the bill so that they might be qualified to appear before a legislative committee, creating a better understanding with other professional groups, and securing speakers on the subject who could appear before lay groups.

Following an extensive report on the conference, Doctor Supernaw recommended that a committee be appointed to start active work with other professional groups on this legislation, and the matter was referred to the Council on Medical Service and Public Relations for action.

Upon motion of Councilor Blumenthal, variously seconded, the meeting adjourned at 3:00 p. m.

C. H. Crownhart,
Secretary.

Approved:
S. E. Gavin, M. D.,
Chairman of the Council.

N. A. WOMACK

WOMACK TO DISCUSS SURGICAL DIAGNOSIS

Nathan A. Womack, M. D., Associate Professor of Clinical Surgery, Washington University, St. Louis, Mo., will discuss "Pitfalls in Surgical Diagnosis," as a feature of the morning program presented in connection with the 1946 Postgraduate Teaching Clinics.

WISCONSIN RAPIDS	FOND DU LAC	MONROE
June 5	June 6	June 7

Have you made your dinner reservation?

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The fat of Similac has a physical and chemical composition that permits a fat retention comparable to that of breast milk fat (Holt, Tidwell & Kirk, Acta Pediatrica, Vol. XVI, 1933) . . . In Similac the proteins are rendered soluble to a point approximating the soluble proteins in human milk . . . Similac, like breast milk, has a consistently ZERO curd tension . . . The salt balance of Similac is strikingly like that of human milk (C. W. Martin, M. D., New York State Journal of Medicine, Sept. 1, 1932). *No other substitute resembles breast milk in all of these respects.*

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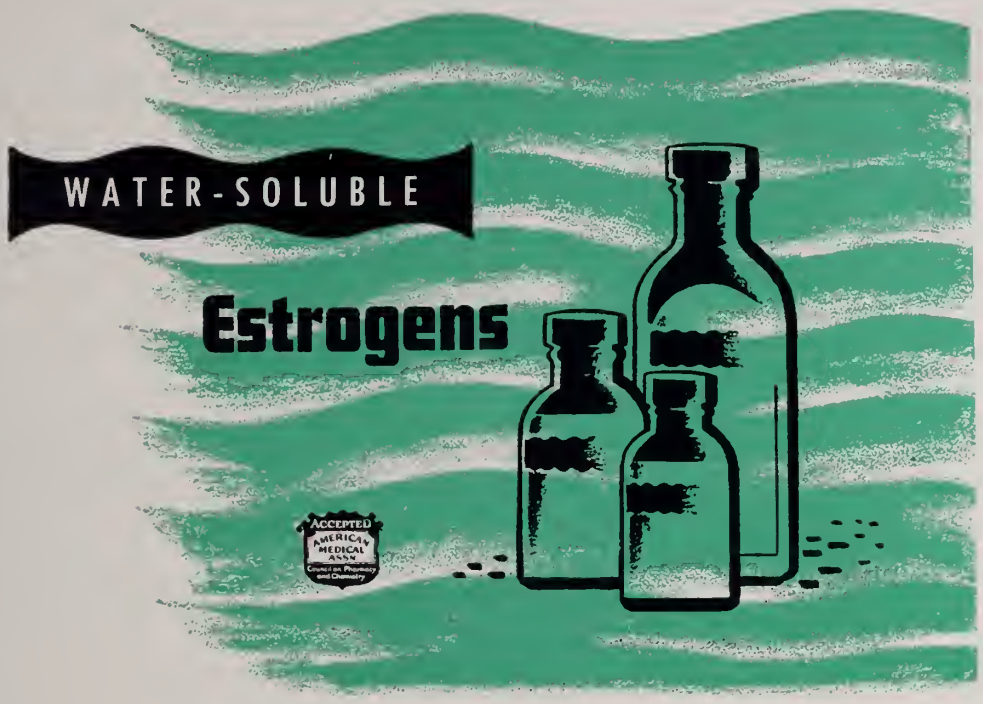
RECENT WISCONSIN LICENTIATES

The Wisconsin State Board of Medical Examiners, at a meeting held in Madison on January 8, 9, and 10, licensed the following physicians in the practice of medicine after they had successfully passed an examination.

Name	*School of Graduation*	*Year*	*Address*
Bringe, James W.	Wisconsin	1945	835 N. Cass St., Milwaukee, Wis.
Cormack, William F.	Wisconsin	1939	Wis. Gen. Hosp., Madison, Wis.
Duckerling, Florence A. (f)	Tufts	1937	Sheboygan, Wis.
Eder, Howard A.	Harvard	1942	910 E. Wisconsin Ave., Milwaukee, Wis.
Gillespie, Noel A.	Wisconsin	1945	770 Langdon St., Madison, Wis.
Gormican, Maurice J.	Marquette	1943	Fond du Lac, Wis.
Grueninger, Anton J.	Marquette	1944	3443 N. Murray Ave., Milwaukee, Wis.
Halfen, David P.	Wisconsin	1944	Sullivan, Wis.
Halvorsen, Martin H.	Northwestern	1945	Elgin, Ill.
Helland, Norman J.	Wisconsin	1944	Stoughton, Wis.
Jamieson, John G.	St. Louis	1943	Racine, Wis.
Kissling, Arthur C.	Wisconsin	1945	3010 N. Frederick Ave., Milwaukee, Wis.
Knutson, Edward W.	Wisconsin	1944	Cumberland, Wis.
Kundert, Karl F.	Wisconsin	1944	Norwalk, Wis.
Manning, Harry J.	Wisconsin	1944	2624 N. 14th St., Milwaukee, Wis.
McCoy, John T.	Iowa	1944	Wis. Gen. Hosp., Madison, Wis.
Nause, Frederick P.	Wisconsin	1945	Cleveland, O.
Reinsch, Paul J.	Wisconsin	1941	Wis. Gen. Hosp., Madison, Wis.
Rence, William G.	Rush	1941	Monroe, Wis.
Rogers, Charles E.	Marquette	1945	6028 N. Kent Ave., Milwaukee, Wis.
Schwarz, Robert J.	Colorado	1944	230 W. Madison St., Milwaukee, Wis.
Scherbel, Arthur L.	Wisconsin	1944	454 Sidney St., Madison, Wis.
Steiner, John H.	Marquette	1945	Stevens Point, Wis.
Steinhaus, John E.	Wisconsin	1945	1021 Sherman Ave., Madison, Wis.
Strewler, Jerome G.	Wisconsin	1943	Racine, Wis.
Vogl, Charles W.	Cincinnati	1944	La Crosse, Wis.
Weinstein, Arvin B.	Wisconsin	1944	1309 Vilas, Madison, Wis.
Willison, Charles H.	Wisconsin	1944	Waukesha, Wis.
Woods, Edward W.	Marquette	1944	Racine, Wis.

The following physicians were granted licenses through reciprocity:

Name	*School of Graduation*	*Year*	*Address*
Ambrose, Stephen E.	Illinois	1932	Whitewater, Wis.
Angevine, D. Murray	McGill	1929	3406 Viburnan Dr., Madison, Wis.
Babbitz, Sidney G.	Wisconsin	1935	2776 N. 55th St., Milwaukee, Wis.
Block, Richard M.	Buffalo	1937	Menasha, Wis.
Bolyard, Nelson Wayne	Chicago	1940	411 E. Mason St., Milwaukee, Wis.
Castaldo, E. Frank	Loyola	1932	Laona, Wis.
Conley, James E.	Harvard	1939	Watertown, Wis.
Denker, Merle Jesse	Loyola	1940	Mountain, Wis.
Easton, James W.	Northwestern	1939	Superior, Wis.
Erbes, John	Nebraska	1939	Columbia Hospital, Milwaukee, Wis.
Foerster, Frederick E.	Pennsylvania	1939	2914 N. Summit, Milwaukee, Wis.
Gamet, Joseph H.	Loyola	1929	Janesville, Wis.
Gautsch, Joseph A.	Marquette	1939	Wauwatosa, Wis.
Greene, Gilbert B.	Tulane	1932	Ripon, Wis.
Griffin, Vernon M.	Oregon	1938	Mauston, Wis.
Grindell, George A.	Washington	1940	Frederic, Wis.
Hilding, Anderson	Minnesota	1919	Duluth, Minn.
Hilker, Albert W.	Chicago	1939	Eau Claire, Wis.
Huron, Willis H.	Ohio	1926	Iron Mountain, Mich.
Jones, Weston W.	Northwestern	1939	Portage, Wis.
Kelley, Orville R.	Virginia	1938	Wausau, Wis.
Kendall, Thurman E.	St. Louis	1940	Wauwatosa, Wis.
Landberg, Harry M.	Loyola	1940	Wauwatosa, Wis.
Leeb, Harry	Bern	1936	2423 N. 44th St., Milwaukee, Wis.
Leuther, Peter	Creighton	1932	Hillsboro, Wis.
Levin, Jack J.	Wisconsin	1934	5409 N. Berkeley St., Milwaukee, Wis.
McCoy, George A.	Indiana	1937	3625 W. North St., Milwaukee, Wis.
McGuire, James P.	Loyola	1928	Milwaukee, Wis.
Meboe, Joseph	Wisconsin	1941	La Crosse, Wis.



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Liquid No. 869 Each teaspoonful is equivalent in potency to one "Premarin" Half-Strength Tablet

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Name	School of Graduation	Year	Address
Moir, William W.	Minnesota	1939	Wis. Gen. Hosp., Madison, Wis.
Nash, Louis R.	Georgetown	1933	Sacred Heart San., Milwaukee, Wis.
Norton, William I.	Wisconsin	1940	341 W. Dayton St., Madison, Wis.
Olson, Lester J.	Minnesota	1943	Spooner, Wis.
Peterson, George H.	Northwestern	1936	Bayfield, Wis.
Rogers, Richard M.	Columbia	1921	Whitehall, Wis.
Ross, Edward	Illinois	1932	1822 N. 17th St., Milwaukee, Wis.
Royce, Owen, Jr.	Tulane	1935	2214 N. Terrace, Milwaukee, Wis.
Siegal, Henry A.	Illinois	1932	Kenosha, Wis.
Smith, Donald R.	Iowa	1925	Iron Mountain, Mich.
Spear, H. Gladys (f)	Chicago	1938	Wauwatosa, Wis.
Stirling, Arthur C.	Rochester	1940	3286 Winnequa Rd., Madison, Wis.
Strauser, Emory Ross	Chicago	1932	Appleton, Wis.
Syphers, C. E.	Coll. Med. Evangelists	1944	La Crosse, Wis.
Thompson, Roger T.	Baylor	1937	Superior, Wis.
Van Kirk, Frank W., Jr.	Rush	1938	Janesville, Wis.
Wade, Chester	Illinois	1937	Oconomowoc, Wis.
Walker, G. A.	Kansas	1935	Racine, Wis.
Wangeman, C. P.	Western Reserve	1933	Wis. Gen. Hosp., Madison, Wis.
Weil, Harry R.	Illinois	1943	525 E. Michigan Ave., Milwaukee, Wis.
Welsch, Raymond G.	St. Louis	1941	Mayville, Wis.
Witt, Everett J.	Rush	1941	630 N. Frances, Madison, Wis.
Youngreen, Harold C.	Wisconsin	1941	Wis. Gen. Hosp., Madison, Wis.
Pick, James W.	Northwestern	1941	2905 N. Summit, Milwaukee, Wis.

At a meeting held in Madison on March 5, the Wisconsin State Board of Medical Examiners licensed through reciprocity the following physicians in the practice of medicine after they had successfully passed an examination.

Name	School of Graduation	Year	Address
Anderson, Wm. A. D.	Toronto	1934	561 N. 15th St., Milwaukee, Wis.
Ashley, Richard Warner	Michigan	1938	Kenosha, Wis.
Beck, Karl H.	Michigan	1939	Child. Hosp., Milwaukee, Wis.
Berg, Owen C.	Chicago	1941	238 W. Wisconsin Ave., Milwaukee, Wis.
Berner, Casper L.	Marquette	1942	Burlington, Wis.
Boland, John D.	Illinois	1938	Mondovi, Wis.
Cunningham, Paul M.	Michigan	1941	Appleton, Wis.
Curtis, John K.	Columbia	1932	3301 Topping St., Madison, Wis.
Dailey, Dee W.	Loyola	1940	Elcho, Wis.
Dangremond, Gerrit	Rush	1938	230 Evanston, Milwaukee, Wis.
Finucane, Patrick J.	St. Louis	1941	Marshfield, Wis.
Foregger, Richard	Marquette	1937	419 Sterling, Madison, Wis.
Harned, John W.	Emory	1924	113 N. Carroll St., Madison, Wis.
Holmes, John F.	Coll. Med. Evangelists	1938	Vet. Adm., Wood, Wis.
Hohf, Arnold H.	Rush	1938	Milltown, Wis.
Kennedy, Richard L.	Chicago	1935	Eau Claire, Wis.
Kodl, Francis W.	Loyola	1936	1801 S. Throop St., Milwaukee, Wis.
Maginn, Richard J.	Rush	1942	Marinette, Wis.
O'Brien, John P.	Jefferson	1935	Fond du Lac, Wis.
Owens, Clarence	Minnesota	1930	1012 Gilson St., Madison, Wis.
Paine, Madison E.	Michigan	1931	Wauwatosa, Wis.
Prichard, Marvin C.	Louisville	1933	Eau Claire, Wis.
Sandin, Howard V.	St. Louis	1943	Ashland, Wis.
Sargent, James W.	Michigan	1943	Milwaukee, Wis.
Schroder, John R.	Minnesota	1939	Janesville, Wis.
Simpson, Reed M.	Washington	1938	Sheboygan, Wis.

PANEL LISTING DEADLINE JUNE 1

All members of the State Medical Society of Wisconsin are reminded that if they desire listing on the 1946–47 Workmen's Compensation Panels, now being prepared for publication, their applications must be on file in the Secretary's office, 917 Tenney Building, Madison 3, Wisconsin *on or before June 1.*

If your application form was mislaid in your office or not received, write for a duplicate immediately.

Even though you do not desire listing please return your blank with such a notation, as it is necessary to have a complete record of the entire membership.

Yours very truly,
R. M. Kurten, M. D.
Chairman, Conference Committee on Open Panels

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Society Proceedings

Barron—Washburn—Sawyer—Burnett

The Barron–Washburn–Sawyer–Burnett County Medical Society met Tuesday evening, April 16, at the Hotel Cumberland for a dinner and business meeting. Members of the Woman's Auxiliary were also in attendance. Mr. A. Osborn, Washburn County Relief Director, was the principal speaker of the evening.

Brown—Kewaunee—Door

Meeting at the Beaumont Hotel in Green Bay on Thursday, April 11, the Brown–Kewaunee–Door County Medical Society heard *Dr. W. S. Middleton* of the University speak on "Some Experiences in the European Theater of Operations."

Dodge

At their March meeting, held on Thursday, March 21, at the Lutheran Deaconess Hospital in Beaver Dam, the Dodge County Medical Society heard *Dr. Chester Kurtz* discuss "Rheumatic Fever."

Dr. Otto V. Hibma, of the Surgical Section of Wisconsin General Hospital, spoke on "Carcinoma of the Rectum" at the meeting of the society held on Thursday, April 25, in the Rogers Hotel.

Douglas

The Douglas County Medical Society met at the Hotel Superior on Wednesday, March 6, and was addressed by Dr. D. W. Wheeler of Duluth, discussing "Medical Experiences in the South Pacific." Discussion of a health program for Superior was continued from the previous meeting. *Dr. J. W. McGill* was appointed to head the cancer clinic, the date for which has not been definitely established.

Eau Claire—Dunn—Pepin

At their March 25 meeting, held at the Elks Club in Eau Claire, the Eau Claire–Dunn–Pepin County Medical Society had the following program: Dr. J. H. Pratt of the Mayo Clinic, "Surgical Treatment of Varicose Veins;" *Drs. J. E. B. Ziegler* and *G. Beebe*, Eau Claire, "Intra-Pleural Pneumonolysis; Presentation of Four Cases."

Dr. Erwin R. Schmidt, Chief of Surgery at Wisconsin General Hospital, was guest speaker at the society's April meeting, held at the Annex Hotel in Arcadia on Thursday, April 18.

Jefferson

Dr. J. J. Harris of Fort Atkinson described some of his Navy experiences at the meeting of the Jefferson County Medical Society held at Shorecrest on Thursday, March 21.

Milwaukee

A Centennial Hall of Health was presented by the Medical Society of Milwaukee County April 27–May 3 in observance of the 100th Anniversary of its founding. Its purpose, according to *Dr. Eben J. Carey*, chairman of the project, was "to portray advances in medicine, dentistry, pharmacy, nursing, and hospitalization in the last one hundred years, and to point the way for progress in the future through medical research."

The exposition included elaborate exhibits by the Bureau of Medicine and Surgery of the Navy, the A. M. A., the Mayo Clinic, and the Jackson Clinic of Madison. Other exhibitors included the State Medical Society, the Wisconsin Anti-Tuberculosis Association, the State Board of Health, the Wisconsin Pharmaceutical Association, the State Dental Society, Marquette University, and many hospitals.

An extensive program of lectures by prominent medical specialists, supplementing the exhibits, was arranged by the Woman's Auxiliary to the county society.

Outagamie

The Outagamie County Medical Society met at the Conway Hotel in Appleton on Thursday, March 21. *Dr. Ovid O. Meyer* of Madison spoke on "Anti-Coagulant Therapy."

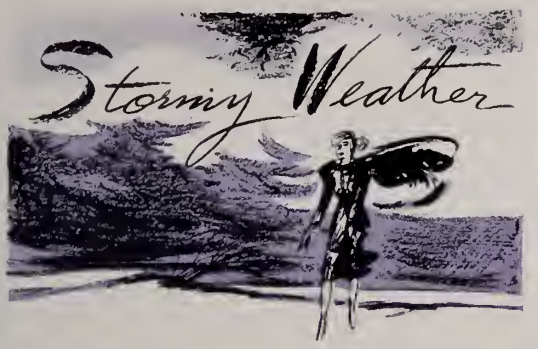
The society held its April meeting jointly with the Winnebago County Medical Society at the Valley Inn, Neenah, on Thursday, April 18. *Dr. James C. Sargent*, Milwaukee urologist recently returned from the Navy, discussed "Common Injuries to the Urinary Tract, Their Recognition and Management."

Pierce—St Croix

Meeting jointly with the Polk County Medical Society on Thursday, March 21, at the Hudson Hotel in Hudson, the Pierce–St. Croix County Medical Society was addressed by *Dr. W. D. Stovall* of Madison. His subject was "Reactions Following Intravenous Procedures."

Sheboygan

The Sheboygan County Medical Society met at St. Nicholas Hospital on Tuesday, March 19, and heard *Dr. C. M. Yoran* of Rocky Knoll Sanitarium, Plymouth, speak on "Tuberculosis." *Drs. J. W. McRoberts, L. W. Tasche*, and *G. J. Hildebrand* were appointed members of the Goiter Committee. The society approved a Cancer Detection Center for Sheboygan County and *Dr. Friedrich Eigenberger* was appointed to a committee to investigate this matter.



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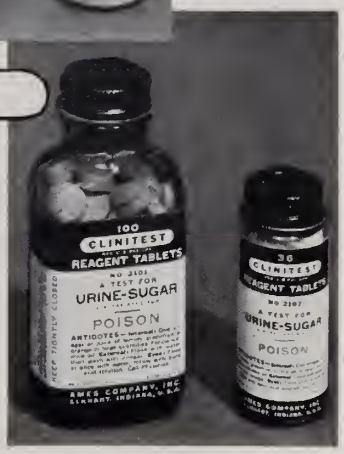

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Walworth

At a meeting of the Walworth County Medical Society held on Thursday, April 11, at the Gargoyle in Lake Geneva, the guest speaker was *Dr. M. G. Peterman* of Milwaukee who discussed "Abdominal Pain in Children."

A joint meeting of the Racine, Kenosha, and Walworth County Medical Societies is planned for June 19, to be held at Big Foot Country Club, Fontana.

Winnebago

The Winnebago County Medical Society held its regular monthly meeting at the Athearn Hotel in Oshkosh on Thursday, April 4. The following scientific program was presented: *Dr. S. R. Beatty*, "X-Ray and Radium Treatment of Cancer;" Dr. Emory Strausser, "Research and Pathological Aspect of Cancer;" and *Dr. F. G. Connell*, "Carcinoma of the Stomach."

Wisconsin Pediatric Society

Dr. Hart E. Van Riper, former Madison physician, now acting medical director of the National Foundation for Infantile Paralysis, addressed the Wisconsin Pediatric Society at their meeting held on Wednesday, April 10, in the University Club. Doctor Van Riper explained the advantages of establishing a poliomyelitis unit at the Milwaukee County Hospital to treat cases from the acute through the convalescent stages.

Milwaukee Oto-Ophthalmic Society

The Milwaukee Oto-Ophthalmic Society met on Tuesday, April 23, at the Milwaukee Athletic Club. The following scientific program was presented: "Ocular Manifestations of Intracranial Tumors in Children and Adults," Dr. Douglas Buchanan, University of Chicago; and "Analysis of Nasal Deformities," *Dr. J. P. Wild*, Milwaukee.

Milwaukee Surgical Society

At the meeting of the Milwaukee Surgical Society, held at the University Club on Monday, April 1, the speaker was Dr. Paul Badgley, professor of orthopedic surgery at the University of Michigan. He talked on "Fractures and Fracture Dislocations." It was announced that the speaker at the May meeting would be Dr. Charles Puestow of the University of Illinois, speaking on "Biliary Tract Surgery."

Milwaukee Academy of Medicine

At a joint meeting of the Milwaukee Academy of Medicine and the Milwaukee Neuro-Psychiatric Society, held on Tuesday, April 30, at the University Club, the following speakers were presented as part of the Centennial Program of the Medical Society of Milwaukee County: "Some Quantitative Aspects of Dementia Praecox," *Lewis Danziger*, Milwaukee Sanitarium (Paper awarded first prize in the Rogers Memorial Essay Contest); "Trends and Progress in Neuropsychiatry," *Hans H. Reese*, professor and Chairman of the Department of Neuropsychiatry, University of Wisconsin Medical School (The Arthur W. Rogers Memorial Lecture).

AND ABOUT THE THIRD DISTRICT:

"With a marked concentration of physicians in the Third Councilor District, the *Journal* experiments by assembling all news items pertaining to activities of physicians in Dane, Rock, Green, Columbia, Sauk, Marquette and Adams Counties and presents them together. The *Journal* urges county secretaries to send personal items of interest. Such notices should reach our office by or before the fifteenth of each month before publication."

—EDITOR'S NOTE

SOCIETY PROCEEDINGS

Columbia—Marquette—Adams

The Columbia–Marquette–Adams County Medical Society held its March meeting at St. Savior's Hospital in Portage on Tuesday, March 12. Their April meeting was held at the Raulf Hotel on Tuesday, April 9.

Rock

Meeting at Mercy Hospital in Janesville, the Rock County Medical Society was addressed by Dr. C. H. Hamann of Rockford, Illinois. His subject was "The Neuropsychiatric Aspect of the Veterans' Rehabilitation."

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What professional men and the public have learned during the war years will be used to advantage during peace time. Ask a Riggs representative about the Rayal "50".

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Beloit, Wisconsin

Sauk

Dr. Harry Vander Kamp told some of his experiences in the Navy with the "Seabees" at the meeting of the Sauk County Medical Society held on Tuesday, March 26, at the Hotel Huntley in Reedsburg.

Madison Society of Medical Technologists

Meeting at the Methodist Hospital on Wednesday, April 13, the Madison Society of Medical Technologists heard *Dr. Michael de Salvo* talk on "The Laboratory Diagnosis and Control of Malaria." Doctor de Salvo spent eighteen months in the malaria control department in the Panama Canal Zone.

COUNCILOR DISTRICT NEWS

Neuropsychiatrist Speaks to Woman's Club

At a meeting of the Madison Woman's Club held Wednesday, April 10, *Dr. Marvin F. Greiber*, clinical associate in neuropsychiatry at the University, discussed "The Returning G. I." The number of neuropsychiatric discharges given from January, 1942, to January, 1945, represented 41 per cent of the total medical discharges for the three-year period, according to the doctor. Doctor Greiber was recently discharged from the Army Medical Corps with the rank of lieutenant colonel.

Dr. Karl Meyer to Speak at Postgraduate Meeting

Dr. Karl Meyer of Chicago will address the next meeting of the Jackson Clinic Postgraduate Group, to be held Thursday and Friday, May 16 and 17, at the clinic. The purpose of these refresher courses is to acquaint postgraduate members with the new developments in medicine as soon as their practical worth has been established. Every effort is made to present programs based on clinical work that may be used in everyday practice.

Any physician who is interested may attend and should make reservation as soon as possible with *Dr. Russell Jackson*, program chairman. Veterans returning from service have an opportunity at this meeting to get a refresher course in civilian practice.

Doctor Larsell Delivers William Snow Miller Lecture

Dr. Olof Larsell, professor of anatomy at the University of Oregon Medical School, delivered the Nineteenth Annual William Snow Miller Lecture at the Service Memorial Institutes Building in Madison on Monday, April 1. Doctor Larsell, a former member of the University Department of Anatomy, discussed "The Anatomy of the Cerebellum as Related to Function." The doctor's varied research interests include particularly the embryology, innervation, and anatomy of the lung and the comparative anatomy of the cerebellum.

SOCIETY RECORDS

New Members

Hance F. Haney, 1922 University Avenue, Madison 5.

Samuel B. Harper, 520 North Pinckney Street, Madison 3.

David T. Schuele, 110 East Main Street, Madison 3.

Palmer R. Kundert, 110 East Main Street, Madison 3.

Leslie E. Coffin, 625 Fifty-seventh Street, Kenosha.

William W. Little, 723 Fifty-eighth Street, Kenosha.

Frederick G. Hidde, 632 North Eighth Street, Sheboygan.

Florence A. Duckering, 1001 North Eighth Street, Sheboygan.

Alfred Wallner, 13924 Weddington, Van Nuys, California.

Burton S. Rathert, Crandon.

George A. French, 504 West College Avenue, Appleton.

Earl E. Dockery, 104 South Main Street, Fond du Lac.

George A. Walker, St. Mary's Hospital, Racine.

Charles W. Connell, East Troy.

Charles H. Behnke, 19 Jefferson Avenue, Oshkosh.

George B. Ridout, 1836 South Avenue, La Crosse.

Roger T. Thompson, 1507 Tower Avenue, Superior.

Dann B. Claudon, 2205 North Summit Avenue, Milwaukee 11.

Vernon M. Griffin, Mauston.

Leonard E. Rothman, 2821 North Frederick Avenue, Milwaukee 11.

Josephine D. Baker, Columbia Hospital, Milwaukee 11.

Wilson S. Phillips, 908 North Twelfth Street, Milwaukee 3.

Philip R. McCanna, 2320 North Lake Drive, Milwaukee 11.

Robert E. Callan, 3320 North Green Bay Avenue, Milwaukee 12.

John Erbes, Columbia Hospital, Milwaukee 11.

John N. Thanos, 747 North Twenty-seventh Street, Milwaukee 3.

Robert S. Haukohl, St. Joseph's Hospital, Milwaukee 10.

Frederick E. Foerster, 2914 North Summit Avenue, Milwaukee 11.

R. J. Dancey, 231 West Wisconsin Avenue, Milwaukee 3.

Shimpei Sakaguchi, 324 East Wisconsin Avenue, Milwaukee 2.

Myron Schuster, 1820 North Seventy-fifth Street, Milwaukee 13.

William A. Mudge, Jr., Negaunee, Michigan.

Donald M. Ruch, 1122 Bankers Building, Milwaukee 2.

Donald M. Willson, 324 East Wisconsin Avenue, Milwaukee 2.

DIAGNOSTIC DILEMMA

A diagnostic dilemma presents itself when the physical examination and laboratory findings are normal in the man of fifty complaining of easy fatigability, nervousness, insomnia, vasomotor disturbances and diminished recuperative power. While such symptoms may be due to psychogenic causes, failing testicular function should be kept in mind. A therapeutic test with ORETON (testosterone propionate) 25 mg. injected five times weekly for two weeks often proves the existence of the male climacteric while the patient benefits.[1]

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1. Heller, C. G., and Myers, G. B.: J.A.M.A. 126: 472, 1944.

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Chester Wade, Box 31, Oconomowoc.

Henry M. Kleinhans, Whitewater.

Albert W. Hilker, Midelfart Clinic, Eau Claire.

Jacob E. Kaufman, 606 Bellin Building, Green Bay.

James M. Fraser, 1018½ Superior Avenue, Tomah.

Raymond G. Welsch, Sheboygan Falls.

Robert J. Rose, 607 Minahan Building, Green Bay.

Roger H. Lehman, Unit A Separation Center, Camp Atterbury, Indiana.

Changes in Address

R. J. Brown, Milwaukee, to Post Office Building, Greendale.

C. J. Newcomb, Milwaukee, to 2110 East Grant Road, Tucson, Arizona.

C. J. Moran, Urbana, Illinois, to Burlington, Wisconsin.

R. F. Kuhlmann, Butler, Pennsylvania, to 300 Longwood Avenue, Boston 15, Massachusetts.

B. J. Birk, Milwaukee, to Cohirk Woods, Thiensville.

F. B. Vande Loo, Appleton, to Wrightstown.

K. D. L. Hannon, Green Bay, to Baraboo.

R. H. Ludden, Viroqua, to 1900 Monroe Street, Madison 5.

L. G. Nezworski, Hawthorne, to 425 Twenty-first Avenue, Superior.

K. A. Seifert, Milwaukee, to 8601 West Greenfield Avenue, West Allis 14.

DEATHS

Dr. Charles F. Harris, 58, former Bloomington physician, died Saturday, April 7, at his home in Klamath Falls, Oregon.

Doctor Harris graduated from Rush Medical College in 1914. He was a member of the Ashland–Bayfield–Iron, Chippewa, Grant, Walworth, and Manitowoc County Medical Societies and the State Society until 1938, when he moved to Oregon. He held a fellowship in the American Medical Association.

His wife and two sons survive.

Dr. Gerhard A. Bading, 75, former Milwaukee mayor and health commissioner and one time United States minister to Ecuador, died Thursday, April 11, in a local hospital after a long illness.

Doctor Bading, who was mayor of Milwaukee from 1912 to 1916, served under Presidents Harding, Coolidge, and Hoover as Envoy Extraordinary and Minister-Plenipotentiary to Ecuador from 1922 to 1930. He was United States Ambassador to Ecuador on three special missions, representative of the Chinese government in Ecuador for eight years, and dean of the Diplomatic Corps in Quito, Ecuador, for six years.

Graduated from Rush Medical College in 1896, he entered practice and was house physician at Milwaukee Hospital for a year. From 1897 to 1901 Doctor Bading was an instructor in surgical pathology at the Milwaukee Medical College, associate in surgery for the next four years, and then professor in operative surgery at the Wisconsin College of Physicians and Surgeons until 1907. He served ten years on the surgical staff of Johnson's Emergency Hospital and was consulting surgeon at the Milwaukee County Hospital. He served as city health commissioner from 1906 to 1910.

Doctor Bading enlisted in the first World War and went to the Philippines as an instructor in officers' training and sanitation, and later to China and Manchuria as chief sanitary officer of the China expeditionary forces. He was honorably discharged as a major. He offered his services at the outbreak of World War II, but his age prevented him from serving.

A past member of the Medical Officers' Reserve Corps, the doctor was a former member of the Milwaukee Medical Society, the Medical Society of Milwaukee County, the State Medical Society, The American Medical Association, and the American Public Health Association. He was a former regent of Marquette University, a life member of the Cruz Roja (Red Cross) of Ecuador, and the Sociedad Simón Bolívar, also of Ecuador.

The doctor's wife survives him.

Dr. Mary Piper Houck of La Crosse died Thursday, March 28, in a local hospital, following a month's illness. Her death, at the age of 80, brought to a close a medical career of fifty-nine years, all spent in La Crosse.

Doctor Houck was a graduate of the Woman's Medical College in Philadelphia, the first medical school to accept women as students. Following her graduation in 1887 she went immediately to the Middle West and established herself in La Crosse. She served on the staff of the La Crosse Hospital from the day it opened.

Her husband, Doctor Oscar Houck, completed his medical studies in 1896 and they practiced medicine together until a year before his death in 1917.

Elected an honorary member of the La Crosse County Medical Society in 1938, Doctor Houck was also a member of the State Medical Society, the American Medical Association, and the American Medical Women's Association. She was a member of the La Crosse Hospital Guild and a pioneer member and former president of the La Crosse Woman's Club.

The doctor is survived by her son, Dr. Knut H. Houck of New York City.

Dr. Norbert M. Kersten, 62, De Pere physician for over thirty-eight years, died Saturday, March 30, in his home.

Doctor Kersten graduated from Milwaukee Medical College in 1907 and associated with his father,

In the Nutrition Problems of
CHRONIC CHOLECYSTITIS

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*Based on average reparted values for skim milk.

Dr. A. M. Kersten, for about ten years, until the latter's retirement.

A former president of the Brown–Kewaunee–Door County Medical Society, Doctor Kersten was a member of the State Medical Society and a fellow in the American Medical Association. He served as an examiner for selective service boards during both wars.

Surviving the doctor are his wife and two sons.

Captain Byrlton D. Lohmiller, 31, Madison physician serving with the Army Medical Corps at Keesler Field, Biloxi, Mississippi, died there Monday, April 1. Captain Lohmiller entered the service August 12, 1943, and was formerly stationed at the AAF Station Hospital at Amarillo, Texas.

Doctor Lohmiller graduated from the University of Wisconsin Medical School in 1942 and interned at Madison General Hospital for about a year before entering service.

Surviving are his wife and one daughter.

Dr. R. C. Morris, 70, well known Fort Atkinson physician, died Tuesday, April 9.

A 1902 graduate of Rush Medical College, Doctor Morris was formerly a member of the Jefferson County Medical Society and the State Medical Society.

The doctor is survived by his wife, one daughter, and two sons.

Dr. Henry E. Twohig, 72, pioneer Fond du Lac physician and surgeon, died Wednesday, April 10, at his home.

Doctor Twohig was graduated from the University of Illinois Medical School in 1900. He was a member of the Fond du Lac County Medical Society, the State Medical Society, the American Medical Association, and the Northwestern Railway Surgeons Association. He was a director of the National Exchange Bank, which he helped organize in 1933.

Survivors include his wife and one daughter.

Dr. Simon B. Spilberg, 56, chief of staff of Mt. Sinai Hospital from 1942 to 1945, and a medical director of the Home for Aged Jews, died Sunday, April 21, at his home in Milwaukee, following a short illness.

Doctor Spilberg was born in Odessa, Russia, and came to Milwaukee in August, 1922. He attended the University of Munich from 1910 to 1914 and received his doctor's degree from the Medical School of the University of Odessa in 1915. He served his internship at Mt. Sinai Hospital in 1922 and has been connected with it ever since.

A member of the Medical Society of Milwaukee County and the State Medical Society, Doctor Spilberg is a fellow in the American Medical Association.

His chief interest was in internal medicine. He contributed to American medical knowledge in the field by translating Dr. O. Naegeli's "Differential Diagnosis in Internal Medicine."

He is survived by his wife and two daughters.

News Items and Personals

Ripon Hospital Elects Officers

At a meeting of the medical staff of the Ripon Hospital held on Tuesday, March 12, *Dr. C. U. Senn* was elected as Chief of Staff and *Dr. J. M. Johnson* was reelected as Secretary. New members admitted to the staff were: Dr. William Schuler and Dr. E. T. Lauterbach, of Brandon.

—△—

Physicians Discuss Adoption of Children

The subject of adopting children was discussed from the medical point of view by three Milwaukee physicians at a meeting of the Adoption Council of Wisconsin, held at the Y. M. C. A. on Wednesday, April 3.

The speakers and their subjects were: *Dr. Milton C. Borman*, Adoptive Parents from the Point of View of Physicians; *Dr. Katharine H. Baird*, What Is an Adoptive Child Medically Speaking; and *Dr. Gilbert J. Rich*, Emotional Factors in Adoption and Being Adopted.

Doctor Kurtz Addresses Masonic Dinner

Dr. Chester M. Kurtz of the University Medical School spoke at the fourth Masonic stag dinner held on Friday evening, April 12, in Fort Atkinson. All physicians in the city received special invitations to attend.

—△—

Superintendent of Riverview Sanatorium Resigns

Dr. C. D. Boyd resigned Monday, April 8, as superintendent and medical director of the Riverview Sanatorium at Appleton, a position he has held for thirty-two years.

Named to the post when the sanatorium was first built, Doctor Boyd also serves on the Board of Directors of the Wisconsin Anti-Tuberculosis Association.

—△—

Navy Medics Praised

Dr. James W. MacGregor of Portage, recently returned from more than three years' service with

(Continued on page 556)

★

Doctors will be interested in the fact that New World Life Insurance Company offers total and permanent disability clauses in policies. These pay 1% disability* and waive premium payments.

*($10,000 insurance carries $100 per month disability income.)

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Mrs. J. C. Fox, La Crosse, President-elect
Mrs. H. J. Heeb, Milwaukee, Vice-president
Mrs. G. J. Hildebrand, Sheboygan, Recording Secretary
Mrs. Leif H. Lokvam, Kenosha, Immediate Past-president
Mrs. R. E. Fitzgerald, Wauwatosa, Parliamentarian
Mrs. J. J. Minahan, Corresponding Secretary, Green Bay
Mrs. N. A. Hill, Madison, Treasurer

COMMITTEE CHAIRMEN

Nominating Committee—
Mrs. Charles Fidler, Milwaukee

Archives—
Mrs. W. A. Wagner, Oshkosh

Finance—
Mrs. F. W. Pope, Racine

Hygeia—
Mrs. J. S. Huebner, Fond du Lac

Philanthropic—
Mrs. A. H. Barr, Port Washington

Press and Publicity—
Mrs. D. L. Dickerson, Madison

Program—
Mrs. A. M. Rauch, Kenosha

Public Relations—
Mrs. J. W. Laird, Appleton

Legislation—
Mrs. E. S. Schmidt, Green Bay

Circulation of Bulletin—
Mrs. D. B. Dana, Kewaunee

War Participation—
Mrs. P. B. Blanchard, Cedarburg

Organization—
Mrs. C. N. Neupert, Madison

MRS C. N. NEUPERT
Organization

Past President of Rock and Dane County Medical Auxiliaries, Mrs. Neupert served as program chairman for the State Auxiliary, 1942–43; legislative chairman, 1944–45; and organization chairman, 1945–46.

Mrs. Neupert has been a member of the Board of the Madison League of Women Voters for two years. She did hospital, canteen, and war chest work during the war.

MRS. D. B. DANA
Circulation of Bulletin

Mrs. Dana, Bulletin Chairman, has served as President of the Brown–Kewaunee–Door County Medical Auxiliary and as state chairman of archives and press and publicity committees. She is active in Red Cross and a member of the Kewaunee County Health Committee and the Kewaunee Library Board.

This year the efforts of the Organization Chairman are being concentrated on the organization of new county auxiliaries, and the reorganization of county auxiliaries, many of which have become inactive during the war.

There has been great need, more acute now than ever before, for the general public to know and understand the problems facing our doctor husbands and the fine work they have been doing in the caring for the sick. We must better understand so that we can intelligently explain the provisions of the bills before Congress which so vitally affect the public and the practice of medicine.

To do this work, we need to have every county with an active auxiliary, with every doctor's wife a working member. The need has never been greater.

The Bulletin of the Woman's Auxiliary to the American Medical Association is issued quarterly and the subscription price is one dollar. This concise, well written little magazine will keep you and your group informed and it will make you proud to belong to the large, friendly, and intelligent society of women who are in the Auxiliary. Without the Bulletin it is difficult for members to realize that they are part of a national organization. Through interesting articles and reports in the Bulletin your national and state officers speak to you. They not only give you guidance but the incentive to helpful work. Other chairmen give you the gist of programs. I urge the circulation of the Bulletin that the best thought of the Auxiliary may come to you.

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Committee on History and Archives

Fortunately the activities of the Committee on History and Archives were not so great during the war, but now that we are in the post-war change maybe every Auxiliary member will have more time to spend on some phase of work for her own county auxiliary.

The purpose of the Committee on History and Archives is to collect and file all material of Auxiliary importance. It is the duty of your state chairman of this committee to file all such material sent her by each county chairman. A letter was sent to each auxiliary chairman last November asking her to send clippings of social activities, resumés of talks at meetings, and all important material. The response has been very slow, but I hope with this little reminder I will be pleased with a response from every county auxiliary.—*Mrs. W. A. Wagner.*

Auxiliary Proceedings

Barron—Washburn—Sawyer—Burnett

The members joined their husbands in a dinner meeting at the Hotel Cumberland, Cumberland, on April 16. Twelve members attended. A. Osborn, Washburn County Relief Director, was the principal speaker of the evening. Following the dinner Mrs. R. C. Thompson, Cumberland, was elected President of the Auxiliary and Mmes. Dale V. Moen, Shell Lake, Alfred E. Muccilli, Spooner, and S. O. Lund, Cumberland, were elected to other offices.

Brown—Kewaunee—Door

The Auxiliary was entertained at tea on Wednesday, March 27, at the home of Mrs. P. R. Minahan, Green Bay. During the afternoon the members addressed posters announcing health radio programs to various local groups, as part of the work which the Auxiliary is doing in the promotion of an educational program in the schools. Mrs. Ernest S. Schmidt, State Legislative Chairman, gave an interesting talk on the hazards of current medical legislation and plans were made to have four study classes during April with Mrs. Schmidt as advisor. The classes will use the material of the State Public Relations committee.

Dane

A luncheon meeting of the Woman's Auxiliary was held at Baron's tea room on Monday, April 8. Mrs. C. F. Sherman was hostess, assisted by Mmes. Allan Filek, Charles R. Bardeen, William Marquis and Stanley J. Briggs.

The March meeting was held Monday, the eleventh, at the home of Mrs. John T. Sprague. Dr. Aasta Stene, of the University of Wisconsin Scandinavian department, was the guest speaker. Mrs. J. A. Hurlbut was hostess chairman, assisted by Mmes. C. F. Schroeder, F. J. Pohle and H. N. Winn.

Dodge

Members of the Auxiliary met at the home of Mrs. R. F. Schoen, Beaver Dam, Thursday evening, February 21. Mrs. R. R. Roberts, vice-president, presided at the meeting. Mrs. George Hoyer reported on the midyear board meeting of the state organization which was held in Milwaukee the preceding week. The evening was spent in sewing on the layette which is to be given to the county nurse for the loan closet. Mrs. L. E. Holmgren, Madison, whose husband addressed the medical society the same evening, was a guest.

On March 21 the meeting of the Auxiliary was held at the home of Mrs. George Hoyer, Beaver Dam, with Mrs. R. R. Roberts, vice-president presiding. Mrs. Chester Kurtz of Madison was a guest. Mrs. A. A. Hoyer reviewed "The Egg and I" written by Betty McDonald. The evening was spent in completing the layette for the loan closet.

Douglas

The Auxiliary was reorganized at a dinner meeting held at the Hotel Superior, Superior, on March 20. Officers elected are: Mmes. Thomas J. Doyle, president; Conrad Giesen, vice-president; Herbert Christianson, secretary and treasurer. The Auxiliary disbanded during the war in order to permit the members to devote more time to Red Cross and other war work. At the first postwar meeting plans to secure speakers for future meetings were outlined.

Fond du Lac

Members met for dinner at the Elks Club, Fond du Lac, Thursday, February 28, which was arranged by Mmes. J. P. Connell and David J. Twohig. Mrs. Leo Hoffmann, Campbellsport, conducted the business meeting during which Mrs. J. S. Huebner, State Hygeia Chairman, reported 23 subscriptions to the magazine in Fond du Lac County. Mrs. J. P. Connell who is in charge of cancer control work, spoke about cancer month and the group decided to hold two meetings in April to work on cancer dressings, a new project. The members voted to give five dollars to the Red Cross. The business meeting was followed by an address by Dr. Robert L. Waffle who told of his experiences in service in the Pacific theatre. Doctor Waffle was introduced by Mrs. Harve R. Sharpe, program chairman.

Mrs. Arthur J. McCarey, state president of the Woman's Auxiliary, was the guest and speaker at the dinner meeting held at the Elks Club on March 28. Her subject was "Hazards Confronting Current Medicine." Hostesses were Mmes. P. G. McCabe and L. J. Simon. Mrs. Leo J. Hoffmann, president, appointed the following committee to select a slate of officers for 1946–1947: Mmes. D. N. Walters, H. A. Devine, and H. E. Twohig.

The members met at the home of Mrs. H. C. Werner during the afternoon of April 25 to make cancer dressings. The group then went to the Elks

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Club for dinner and during the evening continued the work on the dressings. Mmes. C. W. Leonard and L. C. Gardner were hostesses.

Milwaukee

The Woman's Auxiliary met Friday, March 8, at the Hotel Schroeder for luncheon. Afterwards Julie Washburn MacNeill, talented daughter of Dr. Robert Washburn of Milwaukee, gave a dramatic preview of "The Medical Milleniun," adapted from an article which appeared in the 1937 Medical Times. With deft touches of humor, she livened the picture of a world under socialized medicine and prepared the audience for "The worst!" Julie MacNeill studied at Leland Powers School of Drama in Boston and has appeared with various professional groups. Dr. Lucius W. Hipke, president of the Milwaukee County Medical Society, spoke on "Medicine Today and Tomorrow." Doctor Hipke's interpretation and talk was on the true state of America's health as based upon scientific medical data, rather than upon Army rejections and the light this throws on pending dangerous health legislation as proposed by lay people at Washington.

The regular monthly meeting was held Friday, April 12, with a luncheon at the Hotel Schroeder. Mrs. Austin Nichols, instructor in millinery at the Wauwatosa High School, demonstrated the making of hats and had some of her work modeled. Miss Clara Beaupre of Two Rivers, provided songs for the program.

Outagamie

The Outagamie County Auxiliary held a meeting at the home of Mrs. Earle F. McGrath, Appleton, March 21. Assisting hostesses were Mmes. Carl D. Neidhold, David Gallaher, Guy W. Carlson, Frances Cooney, and James W. Laird. Supper was served. Mrs. Ernest N. Krueger, president-elect, conducted the business meeting in the absence of the president, Mrs. F. J. Huberty. Mmes. David Gallaher, Joseph Benton, and Willard O. Dehne were appointed as a nominating committee to select a slate of officers to be elected at the next regular meeting. Mrs. James W. Laird, state public relations chairman, and Mrs. Charles A. Pardee, public relations chairman of Outagamie County, led an informative and instructive discussion regarding problems concerning medical legislation and public health service. Articles relative to this subject were read by Mmes. Carl Neidhold and Guy Carlson. Plans were made to observe National Health Week by presenting a well known speaker to address a public meeting some time between April 29 and May 4.

On Thursday, April 25, Mrs. Arthur McCarey, state president of the Woman's Auxiliary, was guest of honor at a luncheon meeting. Members of the Winnebago Auxiliary joined the group on this occasion.

Sauk

Members of the Sauk County Auxiliary met on March 26 for luncheon. At the business meeting which followed, the group voted to give five dollars to the Red Cross and to bring useful used clothing to the next meeting to be given to needy persons.

Sheboygan

Sheboygan County Medical Auxiliary members met for luncheon at the Grand Hotel, Sheboygan, on February 13. Miss Heiden entertained with an interpretative reading of "The Egg and I," by Betty McDonald. Mrs. Ira Bemis, Batavia, presided at the business meeting which followed. Mrs. Ludwig Gruenewald was the program chairman.

The March meeting was held with a luncheon at the Cottage Tea Room on Wednesday, the thirteenth. Hostesses for the afternoon were Mmes. Wesley Van Zanten and Robert Zaegel. Miss Helen Gunther, daughter of Dr. and Mrs. T. J. Gunther, gave an interesting talk on the "Life of an Army Nurse in Service." Miss Gunther was recently discharged after serving in France and Germany. Mrs. Ira Bemis presided at the short business meeting.

Winnebago

The March meeting of the Woman's Auxiliary was held on the seventh at the Valley Inn, Neenah, for dinner. Mrs. G. R. Anderson, program chairman, introduced the speaker of the evening, John Yoman, well known in the Fox River Valley for his interest in juvenile problems, who spoke on that subject. Mr. Yoman's discussion was the second in a series of programs on child delinquency, one of the subjects for study this year.

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(Continued from page 548)

the Navy, paid a tribute to the Navy corpsmen and medics in a talk before the meeting of the Presbyterian Men's Club held on Tuesday, March 19. Doctor MacGregor was in charge of Base Hospital No. 8 at the height of the Iwo and Okinawa campaigns, holding the rank of commander.

—△—

Dr. Orvil O'Neal of Ripon, speaking before the Rotary Club on Monday, April 1, discussed the trend in diseases which can be postponed or prevented, such as diphtheria, typhoid fever, and smallpox. Some methods employed in inoculation were described.

—△—

New Medical Director of Insurance Firm Named

Dr. E. B. Williams, recently detached from duty as a lieutenant commander in the Navy, has assumed the duties of medical director of the Wisconsin National Life Insurance Company of Oshkosh. He was elected to the position at the annual meeting of the board of directors, held Tuesday, April 9. He has practiced in Oshkosh for the last fifteen years with the exception of the three years spent in the service.

—△—

"What Is Socialized Medicine?" was the subject of a public lecture presented by *Dr. William D. Stovall* at Kenosha on Tuesday, April 9, under the auspices of the Kenosha Medical Society.

—△—

Radiological Section Plans Outing

The radiological section of the State Medical Society is having its spring meeting at Devi-Bara Resort Friday and Saturday, May 17 and 18. Scientific sessions will be held from 2:30 to 5:30 Friday and from 10 a. m. to 12 noon on Saturday. Case reports will be presented, rather than formal papers. Business matters of the section will be taken up, new members introduced, and those returning from service welcomed back.

Complete recreational facilities are available, and a dance is planned for Friday night.

American Congress of Physical Medicine Holds Annual Meeting

The American Congress of Physical Medicine will hold its twenty-fourth annual scientific and clinical session September 4–7, inclusive, at the Hotel Pennsylvania in New York. Scientific and clinical sessions will be given each day. All sessions will be open to members of the medical profession in good standing with the American Medical Association. In addition to the scientific sessions, the annual instruction courses will be held September 4, 5, and 6. These courses will be open to physicians and to therapists registered with the American Registry of Physical Therapy Technicians. For information concerning the convention and the instruction course, address the American Congress of Physical Medicine, 30 North Michigan Avenue, Chicago 2, Illinois.

—△—

New Staff Named at Lakeside Methodist Hospital

Dr. R. W. Adams of Chetek was elected president and chief of staff of Lakeside Methodist Hospital at Rice Lake at a meeting held on Tuesday, April 2. He succeeds Dr. H. C. Wiger who retired from active practice the first of April. Drs. J. F. Maser, Rice Lake, and L. J. Olson, Barron, were named vice-president and secretary, respectively.

—△—

Dean William S. Middleton delivered the principal address at the all-University memorial convocation, in honor of the 485 alumni and students of the University of Wisconsin who died in World War II, held on the campus on Wednesday, May 8, the first anniversary of V–E Day.

President Fred presided at the convocation which was open to all Wisconsin citizens, with parents and relatives of those who died being especially invited.

—△—

Medical Men Speak at Staff Meeting

At the staff meeting of the Theda Clark Memorial Hospital in Appleton, held on Friday, April 26, the following program was presented: *Dr. G. R. Anderson* and *Dr. R. H. Quade* discussed a diabetic case, and *Dr. D. M. Regan* spoke on "The Pituitary Gland."

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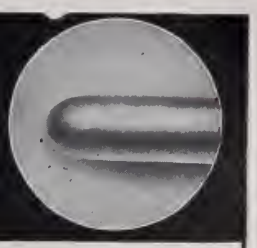

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THE JOURNAL BOOKSHELF

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, S. M. I. Building, Madison, Wis.

Pediatric X-Ray Diagnosis. A Textbook for Students and Practitioners of Pediatrics, Surgery, and Radiology. By John Caffey, A. B., M. D., Associate Professor of Pediatrics, College of Physicians and Surgeons, Columbia University; Associate Pediatrician and Roentgenologist, Babies Hospital and Vanderbilt Clinic, New York City; Consulting Pediatrician, Grasslands Hospital, Westchester County, N. Y. and St. John's Hospital, Yonkers, N. Y. Cloth. Price $12.50 with 711 illustrations. Chicago: The Year Book Publishers, Inc., 1945.

As a textbook of pediatric roentgenology, "Pediatric X-ray Diagnosis" is the first work of its kind to be published in thirty-five years and is the second to appear in English. It therefore fulfills a need which has long been neglected.

The book is arranged according to anatomic regions with adequate cross references in the text to facilitate organization of the complete roentgen findings in a given disease entity. Particular attention is given to the normal and its variations, and to comparison of the changing normal findings during the stages of growth. Also, the author calls attention to faults in technic peculiar to radiographing the infant which may be misinterpreted as abnormalities.

The sections on the head and on the skeletal system are particularly well done. The discussion of the thorax, especially that on congenital heart disease, is somewhat less complete. In general, the text is well illustrated with diagrams and roentgenograms. Reproductions of the actual roentgenograms are of unusually good quality. The space devoted to any one entity is necessarily brief, in a book of this scope, but adequate bibliographies are given at the end of each general subdivision. E. A. C.

A Manual of Surgical Anatomy. By Tom Jones and W. C. Shepard, prepared under the auspices of the Committee on Surgery of the Division of Medical Sciences of the National Research Council. Cloth. Price $3.00. Pp. 254 with 267 illustrations on 138 figures, 153 in colors. Philadelphia and London: W. B. Saunders Company, 1945.

"A Manual of Surgical Anatomy" consists of a set of drawings covering the entire body. The drawings have been very well done and should be of great value to all practitioners of medicine. It must be emphasized that no text is associated with this monograph but that it consists simply of a large series of well done drawings. A. R. C.

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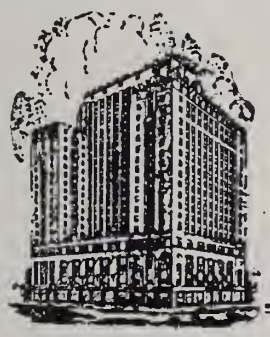

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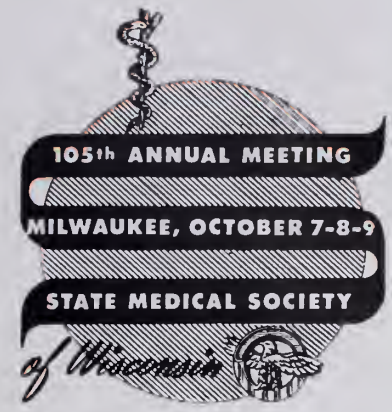

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By Joseph F. Kuzma, M. D., and Myron Schuster, M. D.
TREATMENT OF SOME ANXIETY STATES
By W. S. Muncie, M. D.
EPIDEMIOLOGIC STUDY OF A PRIMARY SYPHILIS CASE
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COMMENTS ON TREATMENT
NOTES ON CLINICAL PATHOLOGY

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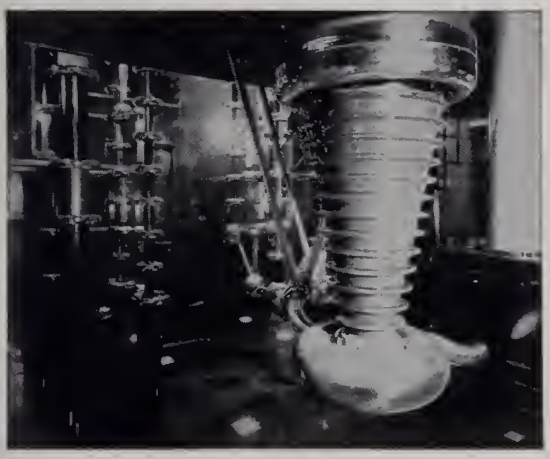

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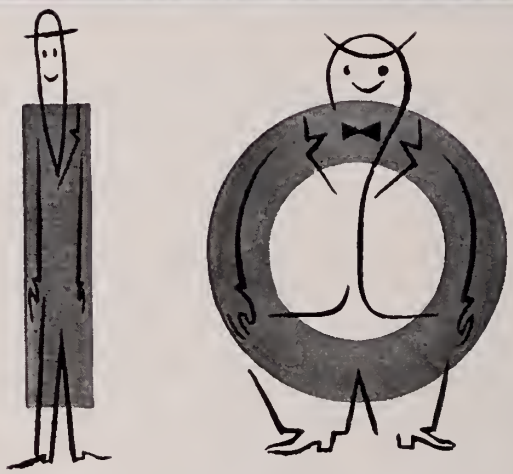

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1. Handbook of Nutrition, Chicago A.M.A., 1943, p. 557.

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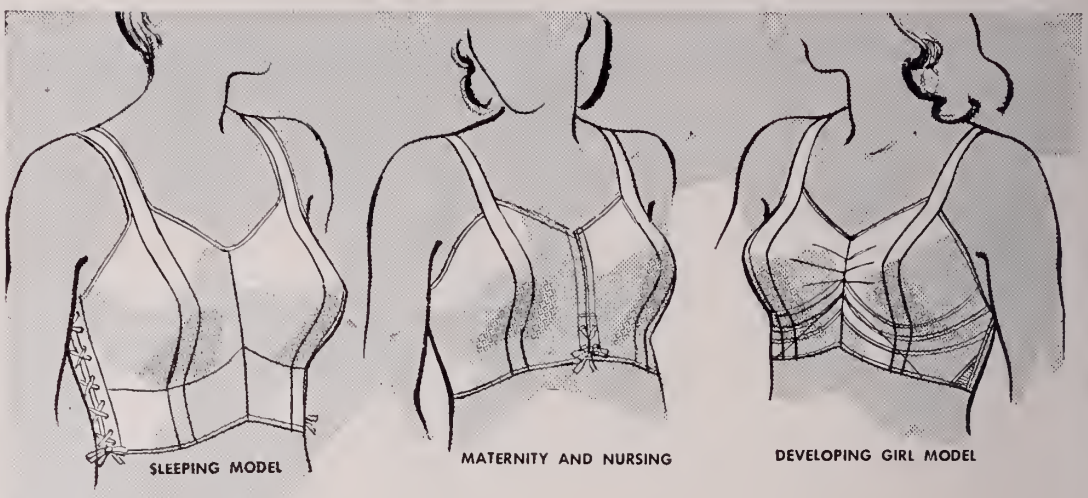

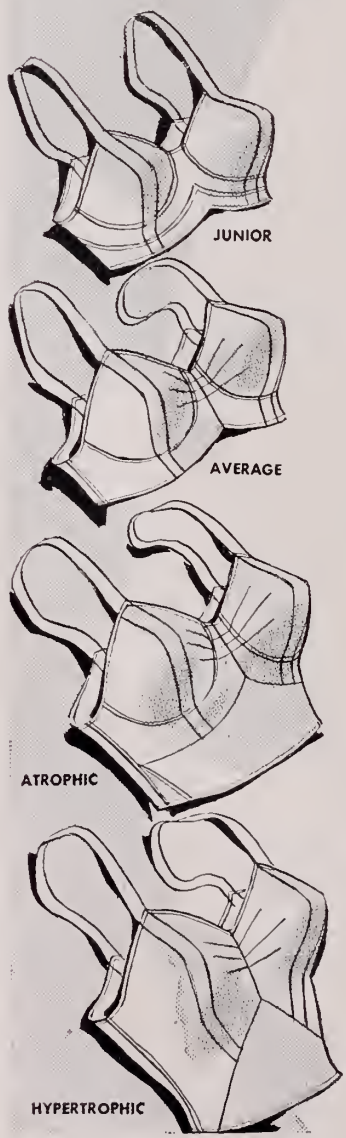

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1. Lehr, D.: Proc. Soc. Exper. Biol. & Med. **58**:11, 1945.
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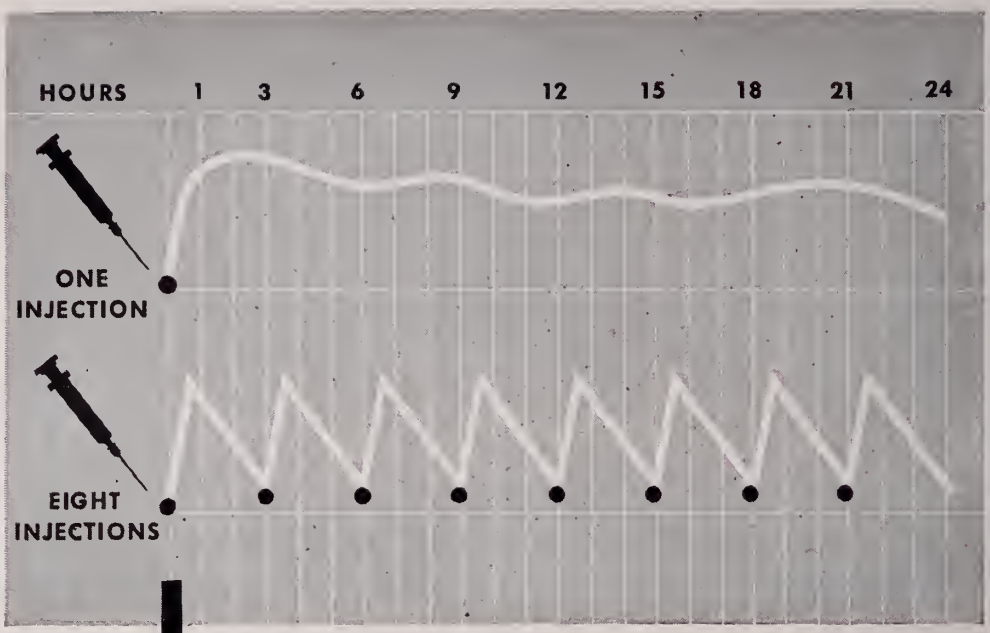

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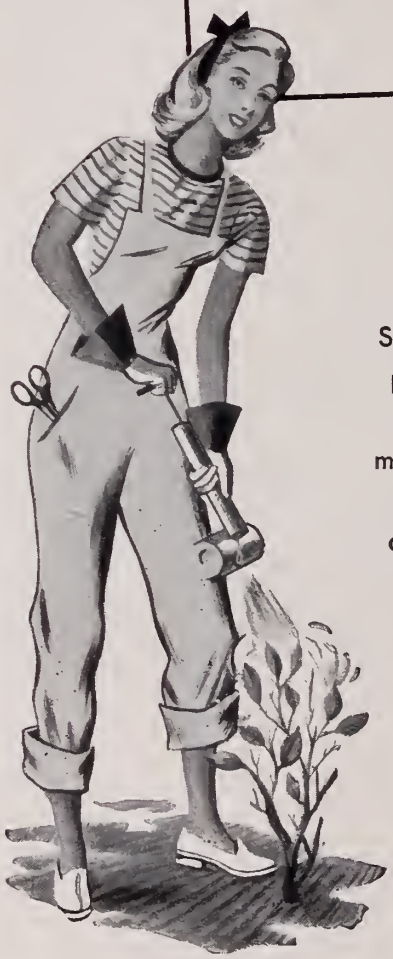

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Histoplasmosis—Reticulo-Endothelial Cytomycosis

Report of a Case From Wisconsin

By JOSEPH F. KUZMA, M. D. and MYRON SCHUSTER, M. D.*

Milwaukee

J. F. KUZMA

Doctor Kuzma, a 1939 graduate of the University of Illinois, is a member of the faculty of Marquette University School of Medicine, Departments of Bacteriology and Pathology; Acting Director of Laboratories, Milwaukee County Hospital; and Director of Laboratory, Milwaukee Hospital.

MYRON SCHUSTER

Doctor Schuster, a graduate of Marquette University in 1941, is Senior Resident in the Department of Pathology of the Milwaukee County Hospital, and a Teaching Fellow at the Marquette University School of Medicine, Departments of Bacteriology and Pathology.

HISTOPLASMOSIS is generally a fatal systemic disease of the recticulo-endothelial system produced by a yeast-like fungus named Histoplasma capsulatum and characterized frequently by weakness, fever, weight loss, hypochromic anemia, and leukopenia. The disease is found predominantly in males and has an age distribution with marked emphasis on infancy, early childhood, and the period after the fiftieth year. The clinical picture is quite variable although the typical case has a combination of findings that may be suggestive. A. In children the gastro-intestinal tract is most vulnerable with the occurrence of intestinal ulcers, both in the colon and small bowel, accompanied by loose, diarrheal stools and discomfort in the abdomen. The lesions may involve the entire length of the gastro-intestinal tract from the oral to the anal orifices. B. Persistent granulomatous ulcerations of the upper respiratory or oropharyngeal regions are suggestive. The cutaneous manifestations are at the nasal oral regions and may vary from papules to ulcers and abscesses. C. The peripheral lymph nodes are frequently enlarged and the enlargement is generally predominantly one group or another. The cervical nodes are involved most frequently. The enlargement is up to 2 cm. Occasionally they may be tender and matted together. The liver is palpable in more than one-half of the cases. Sometimes there may be an accompanying ascites and jaundice. The spleen is palpable in almost the same proportion of cases as the liver. D. Pulmonary findings are variable and sometimes confused with miliary tuberculosis. E. In a rare instance the heart valves or joints may be involved.[1]

The clinical and laboratory relationships are adequately discussed by Parsons and Zarafonetis[2] who have tabulated the essential data of 71 cases. A summary of their tabulations and calculations of the approxi-

* Department of Pathology, Milwaukee County General Hospital and the Department of Pathology and Bacteriology, Marquette University School of Medicine, Milwaukee, Wisconsin.

mate percentages shows the following pertinent points:

Race—63 cases	80% white 11% negroes 9% others
Sex—65 cases	78% males
Age—60 cases	18% occur, within the first year 5 to 8.3% occur within each of the next four decades 53% occur in the age group between 40 and 79 years
Occupation—30 cases	33% farmers 13% laborers
Skin manifestations—61 cases	31%
Oro-nasal manifestations —61 cases	30%
Hepatomegaly—61 cases	64%
Splenomegaly—61 cases	60%
Lymphadenopathy—61 cases	48%
Pulmonary—61 cases	20%
G. I. tract—61 cases	20%
Heart—61 cases	Approximately 2%
Temperature	100–102 F.
Duration of illness	Less than 1 year in majority of cases
Anemia—38 cases	50% between 3,000,000 and 4,000,000 red blood cells
Leukopenia—48 cases	58% had 5,000 or less
Leukocytosis—48 cases	31% had 10,000 or more (2 of these associated with leukemia)
Differential blood count	Not typical
Peripheral blood smears —12 cases recorded	Organisms identified in the monocytes in four cases
Blood protein—7 cases recorded	57% normal total protein but with reversal of AG ratio 43% proteins reduced
Urine—38 cases	63% albuminuria present
Bone marrow—9 cases	56% positive diagnosis
Tissue biopsy—26 cases	100% positive
Cultures—23 cases	In 18 cases positive culture obtained from tissues In 9 cases positive culture obtained from peripheral blood In 1 case positive culture obtained from sternal marrow In 1 case positive culture obtained from sputum

The Histoplasma capsulatum organisms are minute, round, oval, or crescent yeast-like structures with a thick, highly refractile capsule. These organisms reside in the reticulo-endothelial cells of the body. The disease is, therefore, called "reticulo-endothelial cytomycosis."[3] The usual size of the organisms varies between 1 to 5 microns. The central chromatin mass which is clearly outlined by the thick, refractile capsule averages between 1 to 3 microns. These organisms are well stained in preparations of hematoxylin-eosin, Giemsa, Gram-Weigert, toluidine blue, Masson's trichrome and Bodian silver-Best's carmine yeast-fungi stain as described by Kernohan.[10] Diagnosis has been made by finding the organism in the monocytes of the peripheral blood, sternal marrow, and tissue biopsies. Culture makes the diagnosis absolute. It has been cultured on the usual fungus media and is found to reproduce by budding or by mycelial thread formations. The conversion of the mycelial form into budding variety usually requires animal transfer or animal protein enriched media.[4] In this respect it resembles somewhat the cultural characteristics of Blastomyces. It was first cultured by Hansmann and Schenken[5] in 1932 and by De Monbreun[4] in the same year. It can be transmitted to dogs and laboratory animals. Spontaneous canine infection has been found by De Monbreun[6] and Tomlinson.[7] The organism has to be differentiated from Leishmania-donovani and from Toxoplasma. The absence of a kinetoplast and the presence of a highly refractile, thick capsule serve morphologically as the distinguishing criteria. The mode of infection and portal of entry are not clearly understood. According to Pinkerton the gastro-intestinal and cutaneous routes are the most probable portals of entry.[1] He also states that the transmission from insects to man is a possibility.

The first description of the disease was given in 1906 by Darling.[8] He had described three cases in the Panama Canal region. The first case in the United States was reported from Minnesota in 1926 by Riley and Watson.[9] From 1932 to the present time there have been numerous reports from England, Austria, United States, and several southern countries. In the United States there are 56 cases. The states neighboring Wisconsin have all had reported cases: Illinois 4 cases, Michigan 10 cases, Minnesota 1 case, and Iowa 1 case. To date no case has been reported in the State of Wisconsin.

Report of Case

The case is that of a 65 year old, white male who was born in Alsace-Lorraine. He had resided in Milwaukee for thirty-eight years. By occupation he was a sign painter. As a hobby he spent a considerable portion of his time as a dog breeder and was a well-known judge of dogs. The patient had an appendectomy in 1916. Histologic slides are not available. In the summer of 1938 he went abroad and visited England, Scotland, France, Germany, and Switzerland during a period of four months. In the summer of 1939 he visited relatives in Germany. While there he became ill and was treated for heart trouble. He was finally able to return to this country in the summer of 1942 and had no illness until the fall of 1944. At that time he was again treated for heart trouble. In the spring of 1945, because of an insidious onset of weakness and anemia, the patient had liver therapy.

The patient was admitted to the Milwaukee County General Hospital in July of 1945 with the complaints of dizziness, generalized weakness, weight loss (40 pounds in three months), anorexia, shortness of breath, and anemia, coming on over a period of three months. This was insidious in onset. Weakness was so marked that the patient had difficulty in walking.

Physical examination revealed the following. The patient was moderately obese, quite anemic, and disoriented. There were no ulcerations of the skin or mucous membranes. There were no petechial hemorrhages. The lungs were clear. The heart had a normal regular rhythm with a soft systolic apical murmur. The liver and spleen were both palpable beneath the costal margins and both were tender. Cervical, axillary, and inguinal nodes were enlarged and soft. Blood pressure was 115/60. Temperature varied between 99.8 and 101.4 R, pulse between 100 and 120, and respirations between 26 and 40.

During the course in the hospital, which extended over a period of three days, the patient gradually went into a deeper stupor and expired in spite of supportive therapy. Antemortem bone marrow aspiration was attempted but was not successful.

Laboratory Data.—Sedimentation rate was 60 mm. in one hour (Westergren method). Blood count on admission revealed red blood cells 860,000, hemoglobin 3.4 Gm, color index 1.1+, cell pack 10 per cent, M. C. H. 37 micrograms, M. C. H. C. 34 per cent, M. C. V. 111 cubic microns, and white blood cells 1,450 with segmented forms 24 per cent, band forms 36 per cent, eosinophils 2 per cent and lymphocytes 38 per cent (only 50 cells counted). Poikilocytosis and anisocytosis were slight. Reticulocytes were 2.1 per cent and platelets were 37,000. Urinalysis was essentially negative. Blood chemistry revealed an N. P. N. of 66.6 mg.

X-ray examination of the chest showed enlargement of the heart with considerable passive congestion throughout both lung fields.

Postmortem Findings.—The body was moderately obese, having an estimated weight of 200 pounds. Externally the essential findings consisted of gray hair, pale skin surfaces, and mild icteric discoloration of the sclerae. The peripheral lymph nodes were palpable. In the right lower quadrant there was an old surgical scar measuring 20 cm. in length. No petechiae or ulcerations of the skin were found.

Lungs.—The lungs were free except for the left apex which was adherent by easily broken, thin, fibrous adhesions. The lobar demarcations were distinct. The pleural surfaces were smooth and grayish in color. The lung parenchyma was moderately increased in consistency. Sections revealed a grayish-pink tissue which was rather bright anteriorly but of considerably darker hue in the posterior portions. The upper lobe of the right side had a subpleural, posterior nodule measuring 1.5 cm. in diameter. This was sharply demarcated and grayish-white in color. The hilar and tracheobronchial lymph nodes were all enlarged and grayish-black in color. Grossly there was a nodular, grayish, peripheral pattern. There was no change in consistency of these areas as compared with other portions of the nodes.

Heart.—The heart weighed 415 grams. The epicardial fat was abundant and the pericardial sac was firmly adherent. The heart muscle was pale in color, soft, and flabby. In the distal portion of the left ventricle there were large, grayish-white, fibrous patches. Both ventricular chambers were dilated. The valvular apparatus was essentially negative except for moderate thickening and fusion of the aortic commissures. The coronary vessels and aorta showed changes of moderately advanced arteriosclerosis.

Liver.—The weight of the liver was 2,495 grams. Its consistency was relatively firm. The surface was mottled. Cut sections revealed a tan-brown parenchyma with distinct lobular architecture in which the lobules were demarcated by grayish-white portal areas.

Gallbladder.—The gallbladder contained a cloudy bile in which pigment stones were present. The wall was thin and pliable.

Spleen.—The rounded, firm, greatly enlarged spleen weighed 915 grams. Most of the capsule had thick hyaline plaques. Cut sections revealed a moist, moderately softened parenchyma with widely separated, poorly definable follicles. The pulp was reddish-purple in color and swollen.

Kidneys.—The kidneys were approximately the same size. The right kidney weighed 155 grams and the left weighed 145 grams. The parenchyma was grayish in color, swollen, and of indistinct landmarks. The kidney substance was relatively soft. K. U. B. tract was without significant finding.

Adrenals.—The adrenal glands had very small, round, yellowish nodules in the cortices. No caseation was discernible grossly.

G. I. tract.—The gastro-intestinal tract showed no particular change except for the distal portion of the ileum. Here the regional lymph nodes were found to be enlarged. The lymphoid follicles and patches at the ileum were prominent and accom-

panied by minute hemorrhages. There was no grossly definable ulceration. The large bowel had multiple diverticula filled with inspissated fecal material. In the sigmoid there was a glandular, 5 mm. polyp attached by a long pedicle.

Bone marrow.—Sternal and vertebral marrow was found to be abundant but of a rather grayish color and dry and granular in appearance.

Lymph nodes.—The abdominal lymph nodes including periaortic and celiac nodes were markedly enlarged. Many of them were fused, forming masses up to 5 cm. in width. Such nodes had a homogeneous cut section with translucent, pinkish-gray appearance. On dissection of the axillary and inguinal fat the nodes were found to be moderately enlarged and of similar appearance to those described above. No distinctive changes were encountered in the skin, testis, or prostate.

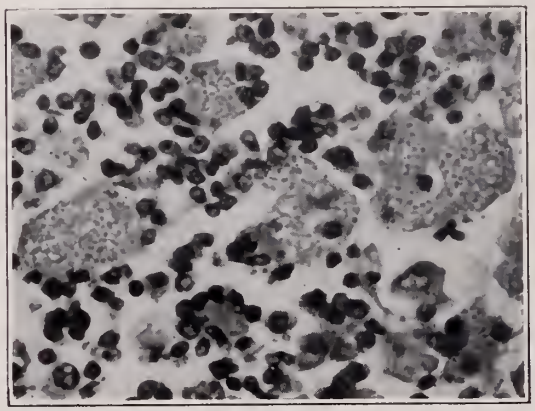

Fig. 1.—High power magnification of the abdominal lymph node (X1500). Photomicrograph shows several very large reticulo-endothelial cells with abundant cytoplasm speckled with the histoplasma inclusions. There are all sizes of the reticulo-endothelial cells, some of which are very small. Occasional free histoplasma bodies can be seen between the cells.

Microscopic Examination.—Microscopic examination revealed generalized involvement of most of the organs with the exception of skin and prostate. The thyroid was not studied. The usual change was an increased number of very large, monocytic cells in all the organs. These were present in inflammatory granulomatous areas without caseation. The monocytic cells contained numerous minute inclusions, each of which was surrounded by a fairly distinct refractile capsule (fig. 1). In the organs such as liver, lymph nodes, and spleen these cells were identified as a part of the reticulo-endothelial system. In the Kupffer's cells of the liver this was very distinct. No inclusions were found in any of the epithelial cells. The number of such cells and the concomitant inflammatory reaction varied in the different tissues. The testis, bowel, and gallbladder had only occasional parasitized monocytes. However, the lungs, lymph nodes, and bone marrow were very markedly involved. The only area of necrosis and caseation was the nodule identified grossly in the

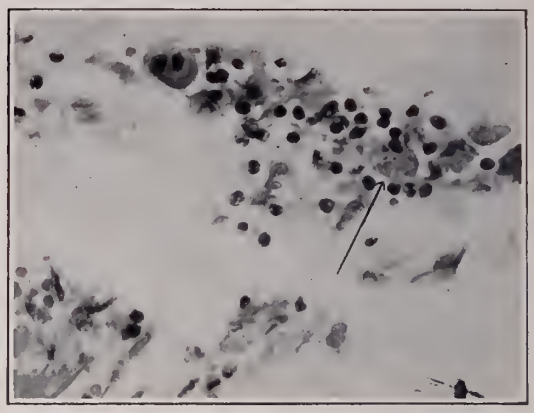

Fig. 2.—Photomicrograph of the interstitial cellular reaction occurring in the heart (X950). There are several reticulo-endothelial cells containing the small crescent shaped histoplasma bodies surrounded by the clear capsules. The other cells are monocytes and lymphocytes. The interstitial edema surrounding the area of inflammation is evident.

lung. This had central, amorphous, caseation necrosis surrounded by a thin layer of fibrillar collagenous tissue. Numerous histoplasma bodies were found in the area of necrosis. In the other organs the focal inflammatory changes were usually not accompanied by giant cells or caseation. The diagnosis was made on the examination of the postmortem sternal marrow smears. The myocardial changes were quite prominent. These were expressions of interstitial myocarditis with focal accumulations of lymphocytes, polymorphonuclear cells, and macrophages. The macrophages contained the organisms. Such cellular changes were accompanied by rather prominent interstitial fibrosis and interstitial edema (fig. 2). Myocarditis has not been emphasized in the previous reports.

Conclusions

A case of histoplasmosis in an adult male who was a dog breeder is presented. It is the first case recorded in the State of Wisconsin. The disease has many expressions involving various organs wherein there is phagocytosis of yeast-like histoplasma organisms by the reticulo-endothelial system. Diagnosis is made by finding the organisms in the peripheral blood, bone marrow aspirations, pus, or stool. The most successful diagnostic procedure is histologic examination of enlarged lymph nodes although the organism should be cultured for absolute diagnosis. There is no therapy which has been found to be effective.

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* Gratitude is expressed to Dr. Henry Pinkerton, St. Louis University School of Medicine, St. Louis, Missouri and Dr. G. H. Hansmann, Milwaukee, Wisconsin who have studied some of the slides from this case.

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Treatment of Some Anxiety States

By W. S. MUNCIE, M. D.

Baltimore

An alumni of the University of Illinois, Doctor Muncie graduated in 1927 from Johns Hopkins University School of Medicine, where he is now Associate Psychiatrist and Psychiatrist Diagnostic Clinic. He took postgraduate training as a Rockefeller Fellow in Europe in 1934–1935. Later he served with the Henry Phipps Psychiatric Clinic, and with the U. S. Veterans Administration, Mt. Alto, Washington, D. C.

The doctor is a Fellow in the American College of Physicians and a member of the American Psychopathological Association.

IN THESE days of short-cut efforts at psychiatric treatment, electric shock, and frontal lobectomy, it may be appropriate to reconsider the principles of treatment derived from psychopathology as applied to anxiety states.

Anxiety is so widespread and appears as a component of so many varied pathologic conditions, that it is perhaps gratuitous to single out certain states as anxiety states par excellence. By this term, we refer to those conditions either episodic or more continuous experienced by the patient as having a strong current of unrest, disquietude, fear, or panic, and usually exhibiting certain of the well-known physiologic accompaniments of such emotions. Principal among these symptoms are: tachycardia, palpitation, dryness of the mouth, shortness of breath, bouts of gastric distress, and diarrhea with weakness and exhaustion, a feeling of imminent fainting or dissolution. The manifestations are protean and are usually called by the internists effort syndrome, pseudo-Ménière's disease, nervous indigestion, spastic colitis, etc., such diagnoses emphasizing the end products, the reaction in terms of the effect on the peripheral organs.

Such conditions must be considered as the reaction of the organism to the fact of an undesirable degree of strain or tension, this in turn deriving from external sources, or from internal sources, or from their combination. For example, in these last years of the war effort, many workers have developed numerous anxiety symptoms arising in people essentially stable and well adjusted to judge them by their past record of general health, work, and satisfactions. In such conditions simple measures have sufficed to bring about relief: medical authorization for additional vacation periods, rearrangement of working hours (e.g., change from the night shift to day shift), or changes in type of work.

In other cases, the external factors, while appearing to bear the burden of the responsibility, actually worked hand in glove with various internal factors of an intensely personal sort, so that in the final appraisal the external factors seemed more in the nature

of incidental provocation. For example, an experienced and steady worker doing long hours overtime in a defense factory, complained of anxiety symptoms, and linked them originally to the monotony of the life of all work and no play. Actually this fact was all the more unpleasant to him because he felt himself unfairly treated in that his long experience and skill received insufficient recognition alongside the crudeness of the newcomer to the plant. His intelligence told him that in the long run, after the emergency was over, he would still be on the job and the newcomers gone, and he would come into his own again, but this vision of the future swing of the pendulum did not suffice to resolve his resentment and the tension symptoms arising from it.

Analysis of Patient's Attitude

In such a case, treatment can succeed only with the clear recognition and acceptance on his part of the basic fact that in war there is much waste and inequity. To accomplish this, an extended analysis of the patient's present attitude is necessary. This would almost certainly lead into several important bypaths which must be understood by the patient—e.g., into his need for perfection in his work, desire for recognition by others, a deep sense of justice, etc., many deriving from early family experience, and being more abstractly rigid than actually and workably realistic. A desire for the good opinion of the physician may serve to activate a melioristic attitude, bringing about a partial resolution of his rigid attitude.

In still other anxiety states there may be no apparent external provocation at all. These are the patients who are completely mystified by the symptoms of the illness, and tend to have their attention and interest soon concentrated on the symptoms as the whole illness, with a relative inability to shift the interest onto a search for hidden causal factors. For example: A young married woman had reached a severe degree of invalidism with a dependence on her husband amounting to a tyrannical invasion of his freedom and effective capacity for work, as a consequence of anxiety attacks amounting to panic. These, coming on shortly after the birth of her only child, now 2 years old, had remained a complete mystery to her. Various physicians had treated the situation by advising the husband to humor and pamper her (shortly after their inception, and related to the popular homage paid to young mothers), to treat her rough, to get mother in to help her, to get the mother out of the home, with bed rest and sedatives, with urging to activity, including buying her a car to make her independent of her husband, etc. After two years of this, and with several false starts to recovery, we were able to interest her in a detailed analysis of the motives at work in the case, insisting from the start that no further good to her would come from more time devoted to reiteration of the symptoms of the anxiety attacks themselves. When she tried to fill up the consultation hour with such material, we forced her to keep to the main task. She was intelligent and interested, and before long she succeeded in discovering within herself a host of difficulties, in the nature of frustrations of deep desires, resentments against her husband and his family, and a feeling of being "pushed about" by others. Ventilation of all these, running them down to their sources, and suggestions for their better management led to steady progress which has been maintained now for a considerable period, with no appearance of any tendencies to relapse. In this case, the treatment difficulties were so great in an early stage that hospitalization was almost necessary. It was avoided when her resistance to the treatment subsided and she could bring herself to collaborate in the investigation.

These are the cases which psychoanalysts have studied, publicized, helped, and theorized about. But not only the psychoanalysts have treated them successfully. A less dogmatic type of psychiatry may achieve excellent results, by a careful analysis of the personality as it is portrayed in waking action, in daydreams, and in dreams, to reveal the conflict of emotions or the frustrations of goals which underlie the symptoms.

In such cases, I assume at the outset no special knowledge except that the symptoms do have ultimately explainable bases at which we may be able to arrive by friendly

cooperation. I suggest to the patient that he come for, say, 6 times with either one of us reserving the right to terminate treatment at the end of that time if it seems desirable. I proceed to obtain an ample history, with special attention to the analogies between present attitudes and early tendencies derived from the family setting with its various allegiances. I utilize the material of the Rorschach test, of dreams, and of those ancient memories which always crop up when the patient's attention is so directed. Usually I see such patients once weekly, but in more severe cases up to 5 times weekly. In some I have secured a capacity to relax and so to avoid panicky states by light hypnosis.

Fruitful Collaboration

In my experience, ample rapport may be established even in weekly conferences, to promote fruitful collaboration, which leaves the patient with the obligation to use the week's time as best he may. Various attitudes develop in treatment, from eagerness to depend on the physician for solutions of his problems to resistances and aversions. All such tendencies can usually be managed by making them the subject for discussion and by suggestions for better management for concrete problematic situations.

When I try to appraise the results of such treatment, my judgment is colored by a relative lack of perfectionism. To summarize impressionistically, enough patients improve, or are apparently cured, to leave with me a sense of satisfaction. I have not hesitated to suggest other types of treatment when it seemed to me my program and its modifications were not adequate.

Office treatment may be pursued as long as the patient is able to follow a relatively useful existence, despite handicap, and when hypochondriacal invalidism has not set in. When this fortunate state does not exist, hospitalization is the treatment of choice. This may be followed by aftercare as necessary on an outpatient basis.

An important intercurrent feature of many anxiety states is a degree of depression. It is of the utmost importance to judge carefully the depth of the depression. It may be only incidental, and easily swayed by many factors, especially those significant for the development of the neurosis, in which case it may be treated sufficiently by reassurance and the maintenance of rapport. Fixed depressive mood on the contrary opposes an effective obstacle to the analytic-synthetic treatment applicable to the more pure anxiety state. In such an event, a waiting game must be followed and a return to the active treatment of the anxiety state is resumed only with the practical resolution of the depression.

To my mind, personality analysis and synthesis constitute the only desirable known methods of treatment of these conditions. Medicinal treatment with sedatives is largely incidental or supportive, and if used at all must not be allowed to run away with the treatment program to the subservience, or submergence of the analysis and synthesis of the personality. Only the latter can offer basic relief.

There are cases in which the chronicity of the illness, or the resistance to treatment, force the physician to compromise and accept symptomatic treatment. Let him make sure, however, that he has judicially arrived at such an evaluation of the case before lowering his therapeutic ambitions. Many a case has been ruined for basic treatment because of the premature use of symptomatic treatment, so fixing the patient's anxiety in a hypochondriacal fashion.

As for shock and frontal lobotomy, there is neither á priori rationale, nor, I believe, sufficient empirical observation to justify their use in these states. They appear, at best, to be the easy device of those neurologizing psychiatrists (to credit them with the utmost in the way of training) who have no experience in actual handling of personality problems, and who in many instances entertain a supercilious disdain for things "mental."

DOCTOR WHITE ON ANNUAL MEETING PROGRAM: Doctor Paul White, noted cardiologist from Boston, is rearranging a trip involving speaking engagements in Mexico and South America so he can appear on the Annual Meeting program in Milwaukee, October 8. He is addressing the Section on Internal Medicine in the morning, conducting a round table that noon, and presenting a paper on the early afternoon program before flying "south of the border."

Epidemiologic Study of a Primary Syphilis Case

By REGINA M. LIND, R. N.

Milwaukee

EPIDEMIOLOGY IN VENEREAL DISEASE

MILTON TRAUTMANN, M. D.*

This is in the nature of an informative article in order to demonstrate to the physician what "epidemiology" can accomplish with his cooperation. This goes, of course, for any contagious disease. However, applied to venereal disease the work done and results accomplished are quite outstanding. Yet, they represent only the usual travels of the *Spirochaeta pallidum* among the human family but illustrate again the ease with which these diseases remain concealed and therefore are an ever potent reservoir for reinfection.

To clinch the point, we should like to repeat for the "umpteenth" time that the State Board of Health has nurses, doctors, and four full-time "investigators" ready and willing to assist the physician in this epidemiologic work throughout the state.

Although it may not be the policy of *The Wisconsin Medical Journal* to publish material by nurses, yet this is of enough general interest that we venture to publish the study. The initiative illustrated in writing up a routine piece of work by the nurse is also recognized.

* Former Director, Venereal Disease Division, Wisconsin State Board of Health.

WE ARE submitting herewith a history of the follow-up work of the state venereal disease control department in the Milwaukee area on a case of primary syphilis involving ten persons, eight of whom were found to be positive for syphilis. The study of this case involves one agency and several private doctors who have so splendidly cooperated with the state department in this epidemiologic study. In discussing the case with the various physicians we have found them very cooperative and interested in the follow-up work done, and all were in favor of having all the cases reviewed in six months' time to learn the progress of the several cases herein cited.

On Nov. 14, 1945, a discharged war veteran, white, born Feb. 12, 1916, was referred from the Veterans Administration with a penile lesion, having been referred to the Veterans Administration by a private doctor because of a suspicious lesion and a positive darkfield examination. Upon examination at the Social Hygiene Clinic he was found to have a positive darkfield and blood Kahn X, and was diagnosed as primary syphilis.

In interview this patient disclosed that he had picked up a white girl in a Milwaukee tavern and had relations with her, but only knew her by her first name. He was advised to go back to the tavern and try to learn her full identity before being sent to the hospital for penicillin therapy, to return to the clinic for post-penicillin observation.

On Thursday, the 15th, when this patient was interviewed at the hospital by the venereal disease control nurse with reference to his contact he stated he did not go back to the tavern as he was requested to do, but gave the nurse the address of the tavern and the girl's first name.

Contacts

Contact No. 1—This contact was named by the above patient. Her last name was unknown and the only information we had on the girl was her first name and that she "hung around" a certain tavern. The state V.D. control nurse made a call at the tavern and after considerable persuasion the tavern owner finally admitted knowing where the girl lived, but did not know the street number nor her last name, and offered to show the nurse the house in which she lived. He further informed the nurse that this girl had been married in the spring of 1945 to a sailor who was, at the time of this investigation, overseas. On going to the home, the nurse was admitted by the girl's mother, who informed the nurse that the girl was working and would not be home until 11 o'clock that night.

During the conversation the nurse asked the married name of the girl thus finding out her last name. A message was left with the mother for the girl to report to the Social Hygiene Clinic the next day, Friday, November 16. On Friday morning the girl telephoned that she could not report to the clinic because she had "too many things to take care of" as her husband was being discharged from the Navy and was expected home that night. She was informed that she would have to report to the clinic immediately as we had an important matter to discuss with her concerning her health. She reported about ten o'clock on the 16th. She was found to be white, born Nov. 21, 1926, married May 12, 1945, and at that time was living with her parents, but gave information that she had lived downtown in a rooming house section for several months after her marriage. She admitted extramarital exposures to two men, but would not give the name of either of them stating she would contact them herself.

Upon physical examination her genitalia revealed an atypical lesion and condylomata lata of secondary

syphilis on right labia majora; also a macerated lesion of the vagina. Darkfield examination was negative for spirocheta pallida and quantitative Kahn was XXXX containing 240 Kahn units. Smear was suggestive but culture negative for gonorrhea. The diagnosis was secondary syphilis, and she was sent to the South View Hospital that same day for penicillin therapy. Upon dismissal from the hospital she returned to the clinic on Nov. 26 for post-penicillin observation.

The husband was discharged from the Navy the same day the contact was sent to the hospital. After learning of his wife's condition at the hospital, he immediately left her and went to live at his parents' home which is out of the state. The girl was later interviewed on several occasions about the possibility of exposing her husband, but denied any sexual relations with him since he returned from the Navy, stating that he will sue for a divorce because of this condition.

When questioned concerning her contacts she informed the nurse that she had not mentioned anything to the men who were her contacts about being examined. She said she knew the one in the Army was receiving treatment for syphilis. She gave the name of the other, but did not know his home address, and gave the nurse the name of his employer.

Contact No. 2—This contact was named as a contact to No. 1. Not having his address we sent a letter, marked "personal" to him at his place of employment, asking him to report to the Social Hygiene Clinic on November 20. He did not report as requested, but a private physician telephoned the clinic on Nov. 20 that a man having a letter from us asking him to report to our clinic had come to his office the night before, but the name under which the man was registered with the doctor was entirely different from the one given us by the contact. The man informed the physician that the name we had used was one he frequently used. Not knowing why the man was wanted (our first letter does not state specifically), and not being able to contact us during the evening when our clinic was closed, the doctor drew a blood on the man and sent it to the laboratory for serologic examination. The doctor stated that this man had reported at his office on November 7 with a penile lesion, but did not come back until Nov. 20 after receipt of our letter. The result of the blood test was P4 for syphilis, and treatment was begun by the doctor on Nov. 21.

On March 1, 1946 the doctor informed the state V.D. control nurse that the patient had been delinquent in treatment for the past two weeks. A letter was sent by the V.D. division to this patient to report back to his doctor for treatment or report to the Social Hygiene Clinic to show cause why he was not reeciving his treatment. On March 6 the doctor was contacted and he stated that the patient had not reported back to him. On March 7 a call was made by the V.D. control nurse at the man's home. There was no one at home so a message was left for the patient to telephone the clinic, and on March 8 this patient telephoned the nurse that he was returning to his private doctor.

At this time he was asked why his wife had not reported to the private doctor for serologic test for syphilis as requested by the doctor, and he stated that his wife was examined by another private doctor, was found to be positive and is now receiving treatment there. Verification was received from the doctor on March 18.

Contact No. 3—This is a contact to Contact No. 1. No. 1 would not reveal his name, stating that he is a soldier overseas and that she had been told by him that he had received antiluetic treatment in the Army.

Contact No. 4—This is the wife of Contact No. 2 who was advised by his physician to bring his wife in for a check. Serologic tests for syphilis were done by the private doctor on Nov. 26, 1945, and both Kahn and Wassermann were negative. She was advised by the physician to report back for another check in one month's time. To date we find she has reported to a doctor, has been checked by him and found to be positive. On March 18, 1946 the physician reported this contact under treatment with him for secondary lues since Feb. 7.

Contact No. 5—This is also a contact to Contact No. 2. Her name was obtained through the efforts of the private doctor who had Contact No. 2 under his care. The doctor reported the name of this contact to the Social Hygiene Clinic for further follow-up work, and on Dec. 12, 1945 a letter was sent asking her to report to the clinic and she reported on Dec. 13. She was white, born May 26, 1917, married and living with her husband who had recently been discharged from the armed forces. She admitted exposure six weeks previously.

Upon physical examination at the clinic a suspicious ulcerated area was found on the cervix, but a darkfield of this lesion was found to be negative. The blood Kahn was negative. Gonorrhea smear was suggestive and the culture was negative. She was advised to report back to the clinic on Dec. 17, at which time no evidence of venereal disease was found. She was instructed to have repeated blood tests for the next two or three months, which tests could be done by her private physician if she desired. She informed the clinic that she would report to her own doctor for further follow-up service and would send in the name of the private physician.

By Jan. 4, 1946 she had not contacted the clinic to give the name of the physician under whose observation she was to be, so a letter was sent to her requesting the name of the doctor. On Jan. 7 she reported the name of the doctor to whom she would go for further observation. On Jan. 10 our request was sent to the physician for verification of the patient's statement, and on Jan. 14 we received the verification with the diagnosis of secondary lues.

On Feb. 20 a call was made on the physician in this case by the state V.D. control nurse, and the following information was given relative to the above patient.

On Jan. 7 she had reported to the doctor informing him that she was referred to him by the Social Hygiene Clinic for observation because of having been a contact to a case of primary syphilis. On that date the serologic test was Kahn X. On Jan. 11 she had a rash over her entire body and reported back to the physician. A diagnosis of secondary lues was made and anti-luetic treatment was begun on that day.

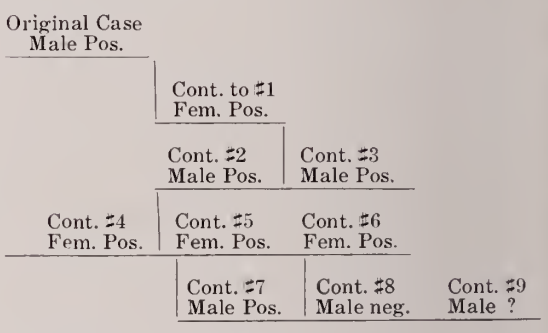
Contact No. 6—This is also a contact to Contact No. 2. Her name was given to the V.D. control department by the private physician who was treating Contact No. 2. A letter was sent to her by the V.D. department on Dec. 12, 1945 and she reported to the clinic on Dec. 13. She is white, born Sept. 12, 1921, married and living with her husband who had been released from the Army. She admitted extra-marital exposure. On physical examination no lesions were detected on the genitalia. A moderate amount of vaginal discharge was found. Blood was drawn for a serologic test, and she was asked to return to the clinic on Dec. 18. The Kahn was found to be XXXX, smear for gonorrhea was suggestive, but culture negative. At that time another Kahn was drawn which was found to be XXXX, and a diagnosis of early latent syphilis was made. She was placed on the Army plan of treatment at the Social Hygiene Clinic until such time as she may transfer to her own doctor.

After receiving two anti-luetic treatments at the clinic, on Dec. 27 she informed us that she would report to a private physician. The doctor's verification of this statement was received on Jan. 9, 1946. A call was made on the doctor on Feb. 28, and he informed us that this patient is very cooperative.

Contact No. 7—This is the husband of Contact No. 5, and information on him was given to us by the private doctor who was caring for Contact No. 5. Through the doctor's efforts and suggestion, Contact No. 7 was examined by him on Jan. 11 when he reported to the doctor's office on complaint of not feeling well. The blood Kahn on that date was negative, and he was told to return on Feb. 15 when a complete physical examination was done and the patient was found to have a penile chancre and inguinal adenopathy, and penicillin therapy was ordered for him by his doctor. Both contacts No. 5 and No. 7 were reported very cooperative by the private physician.

Contact No. 8—This is the husband of Contact No. 6. He came to the Social Hygiene Clinic on Dec. 26, 1945 after we had instructed his wife (Contact No. 6) to have him report for a check-up. A complete physical examination was made, but no lesions or discharge were detected on the genitalia, and the patient denied having had any lesions at any time. On Dec. 26 the Kahn was found to be negative. The patient was advised to have repeat blood tests monthly for three months. On Feb. 5, 1946 he returned to the clinic and the Kahn was negative. On Feb. 26 he transferred to his private physician and a Kahn was done at that time and reported negative.

Contact No. 9—This is a contact to Contact No. 6. She admits the exposure, but is reluctant about giving the name of the man. The private physician on the case will try to get the name and report it to the venereal disease control division for the follow-up service.



Original Case— Positive 1
Contacts:
Males— Pos. 3
Neg. 1
Pending 1
Females— Pos. 4

SPECIAL VETERAN FEATURES PLANNED FOR ANNUAL MEETING

All veterans planning to attend the annual scientific assembly in Milwaukee next October 7–8–9, are urged to participate in several special features planned for returning war members. The Council of the State Society has provided for a special reception and buffet supper for all veteran members Monday evening, October 7, and plans are under way to provide a special luncheon the following day, which will be devoted to medical topics of special interest to veterans. A special committee may be formed to assist with details of the program.

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Iron

Presence—Fowler (1941) says there are 2.5 Gm. of iron in the hemoglobin of the red cells, 1.3 Gm. in labile storage, 0.6 Gm. in unavailable storage, a very small amount in the red cells unassociated with hemoglobin, and a small but important fraction in the blood plasma.

Absorption—Moore's (1944) studies employing radioactive isotopes showed that absorption occurs through the epithelial mucosal cells of the small intestine into the circulation by way of the capillaries and not through the lymphatics, and that the mucosa accepts iron readily only when the reserve stores are depleted; i. e., the body protects itself against excessive accumulation of iron simply by refusal to absorb it from the intestine.

Transport and Conversion—Iron is transported from the intestinal mucosa to the storage organs and from them to the bone marrow (in cases of great need apparently passing directly from the intestine to the bone marrow) dissolved in the plasma; i.e., that small amount of plasma iron previously referred to is iron in transport. In the bone marrow it is taken up by the nuclei of erythroblasts, and when hemoglobin has been formed from it the nuclei are extruded and the mature non-nucleated hemoglobin-bearing erythrocytes pass into the circulation. In the early stages of iron therapy some of these young erythrocytes still retain their reticulum and thus afford an index of the patient's response.

Storage—Labile iron is obtained through absorption from the gut, and also as a result of the continuous physiologic destruction of red cells; it is stored in the reticuloendothelial cells of the liver, spleen, kidneys, and bone marrow, and apparently to some slight extent in the skin also.

Excretion—The studies of Heath (1943), employing colonic explants and also radioactive isotopes, revealed that iron may truly be called a "one-way substance"; i.e., it may or may not be absorbed according to the requirements of the body, and when not absorbed it will be eliminated in the stools, but in any ordinary sense it is not excreted.

Necessity for Administration—Following acute blood loss, hemoglobin is regenerated with iron from the storage depots at the rate of 1 per cent per day without appreciable passage of iron through the intestinal mucosa; but once the stores begin to be depleted through chronic or very severe acute bleeding, food iron rapidly enters the blood. However, the stores cannot usually be replenished with food iron alone since the average American daily dietary iron is only 10 to 20 mg. and the amount required to regenerate 1 per cent hemoglobin per day is 25 mg. (100 per cent of hemoglobin represents 2.5 Gm. of iron, 1 per cent of which is 25 mg.). Hence medicinal iron must be administered in these cases.

Choice of Preparation—Ferrous sulfate is the iron salt least likely to cause gastrointestinal irritation, which is fortunate since empiric observation plus the careful studies of Moore (1944) have fully established the fact that in man there is much better assimilation of this than of other forms of iron. Ferrous sulfate oxidizes to the less effective ferric compound when exposed to air, but the 3 grain (0.2 Gm.) coated commercial tablet is stable; average adult dosage is 4 such tablets, 1 after each meal and 1 upon retiring. There is also commercially available an elixir of ferrous sulfate; Reznikoff (1944) says the adult may be built up to a dose of 3 teaspoonfuls (about 12 cc.) three times daily after meals, but it seems to me inadvisable to use iron in solution as it may stain the teeth even though taken through a tube.—HARRY BECKMAN.

Notes on Clinical Pathology

Editors—WALTER H. JAESCHKE, M. D., University of Wisconsin, Madison, and
S. B. PESSIN, M. D., Marquette University, Milwaukee

The Cephalin-cholesterol Flocculation Test of Hanger

Among the various procedures now enjoying a certain degree of popularity in the study of disorders involving the liver and biliary tract, is the relatively simple cephalin-cholesterol flocculation test which was introduced by Hanger in 1938 as an aid in the differential diagnosis of hepatogenous and obstructive jaundice. It was Hanger's conclusion that the test tended to be positive in the former and negative in the latter; also, that the test was more sensitive in the detection of liver dysfunction than the commonly employed function tests.[1, 2]

Careful study of the procedure by Pohle and Stewart[3] as well as others[4] seems to have confirmed its reliability as an empirical test of active liver damage, but has indicated that it is not a reliable guide for the differentiation of hepatogenous from obstructive jaundice.

The actual mechanism of the test is not clearly understood although Hanger and his associates believe that an increase in gamma globulin over the normal, results in the flocculation of the cephalin-cholesterol preparation.[5]

As more and more studies are reported in the literature the following points are worthy of note:

1. The test is more reliable if the 1 plus tests are regarded as within normal limits and positive diagnostic importance attached only to 2 plus, 3 plus, and 4 plus tests.[6]
2. Exposure of the test to direct sunlight results in numerous false positive; a dark cabinet causes a high percentage of false negatives.[7, 8]

We have had satisfactory results with the unripened cephalin prepared from fresh sheep brains according to the formula in Hanger's original publication[1] and with the product of the Wilson Laboratories of Chicago.

Principle

The cephalin-cholesterol test of Hanger is a test of unknown mechanism which demonstrates the ability of blood serum to flocculate a colloidal suspension of cephalin-cholesterol when active liver damage is present. Reactions are expressed in terms of 1 plus, 2 plus, 3 plus, and 4 plus, and thus give a quantitative estimation of the degree of liver impairment. In a negative test, the emulsion remains a homogeneous suspension throughout as when the test was set up. A 4 plus reaction consists of a complete precipitation of the emulsion with a water clear supernatant. 3, 2 and 1 plus reactions are graded accordingly.

Preparation of the Emulsion

1. Place exactly 35 cc. of freshly distilled water in a carefully cleaned beaker warmed in a water bath to 65 or 70 C.
2. Add slowly and with stirring 1 cc. of the stock ether solution of cephalin-cholesterol. Heat *slowly* to boiling.
3. Simmer the mixture until the final volume is 30 cc. (have a 30 cc. mark on the beaker). During the heating all coarse granular clumps are dispersed to a stable, milky, translucent emulsion, and all traces of ether are driven off.
4. Cool to room temperature before using.

Procedure of the Test

1. Obtain venous blood from the patient; allow to clot and centrifuge. (Serum is better when fresh, but it may be allowed to stand at icebox temperature.)
2. Place 0.2 cc. of clear serum in a centrifuge tube and add 4 cc. of physiological saline.
3. Add 1 cc. of the emulsion prepared above.
4. Shake well and stopper the tube with cotton. Leave at room temperature in subdued light for 24 hours when readings are made. (Hanger reads the test after 24 and 48 hours. It has been our custom as well as that of others to make only the 24 hour reading.)
5. Set up a salt solution control and a normal serum control each time the test is run.

Discussion

1. Positive results are obtained in a very high percentage of patients with diffuse parenchymatous liver disease.
2. Lesser percentages of positive reactions are found in focal disease of the liver.
3. Negative reactions are occasionally encountered in the presence of mild liver dysfunction.
4. Occasional apparent false positive reactions occur. These have been noticed in the presence of allergic diseases and during the puerperium and neonatal period especially.[4]

(Continued on page 642)

As It Looks From California

Wisconsin is but one of many state, area, or specialty medical societies. Its perspective is that of a mid-western state. But its problems, at least in part, are also problems elsewhere. These pages are provided periodically for the reactions of medical leadership in other parts of the country.

JOHN HUNTON

As Executive Secretary of the California State Medical Association Mr. Hunton has been in the publishing and public relations field for twenty-two years. In 1926 he married Mary Ellen Rogers, niece of the late Dr. Arthur W. Rogers of Oconomowoc, who served the State Medical Society of Wisconsin as its President in 1927 and Chairman of its Council for eight years.

AN EASTWARD view from the Pacific reveals the same sight that many others farther east have seen with their own eyes. Medicine has one choice to make—will prepayment of medical and hospital bills come by voluntary means or compulsory? There can be only one answer and this answer lies within the grasp of the profession itself.

California has been facing various forms of compulsory health insurance since 1917, when a Lady-Bountiful state Legislature voted an idealistic form of compulsory health insurance. However, in that year the issue was put up to the voters on a referendum and the public voted against the legislative bill by a margin of better than two-to-one. Since that time there has been some form of compulsory health insurance before the Legislature on numerous occasions, with at least one bill introduced in every biennial session from 1933 to date. The medical profession is getting used to fighting this battle.

But even though the legislators have not actually adopted a system of compulsory health insurance there remains a public demand for some method of budgeting the costs of medical and hospital care.

Today the big question in California remains as before—compulsory or voluntary? The physicians have met the issue by assessing themselves annual dues in an unprecedented amount and applying the proceeds of these dues to the promotion of the voluntary forms of sickness insurance. And by the voluntary forms they mean *all* voluntary forms. Commercial insurance, California Physicians' Service, closed panel groups—any expression of the voluntary method of prepayment of unpredictable costs.

Lest this broad outlook be misinterpreted, it should be mentioned here that the physicians of California have separated the various problems in this field and are taking on one at a time. The philosophy is about this: If the voluntary systems of sickness insurance are actually able to prove themselves worthy, the compulsory systems will disappear. If the compulsory systems are dropped, then the voluntary systems should compete with each other, and may the best man win. If commercial insurance, for instance, offers the public the best package, then the doctors' own plan must either compete actively or go out of business.

The ultimate thought, of course, is that the public is and will continue to be the best judge of what it wants. We may sit in our offices and attempt to take a vicarious pulse on public opinion but in the long run the public itself will supply the answer. Suffice it to say that there has been a public demand for some form of prepayment of medical and hospital costs over a long period of years; the public will eventually select its own expression of prepayment, whether it be a nonprofit medical plan, a commercial insurance plan, or a government-sponsored and government-controlled compulsory plan.

Along with waiting for the public to decide which method of prepayment it prefers, medicine must take upon itself the obligation of keeping our legislators informed on what is going on. Unless this is done, some of our state or federal legislators may go off on a tangent and push through some legislation which will be harmful to the public and the profession alike.

(Continued on page 642)

As It Looks to Your State Board of Health

(These timely discussions of health problems are prepared by staff members as a special service to Wisconsin's physicians.)

Partners in Tuberculosis Control—II*

Is this good? We'll present the facts—you be the judge.

The number of active cases of tuberculosis on record has increased consistently and reflects the impetus of case-finding programs as well as the greater interest of physicians in reporting cases to the local or state health departments.

BUT—and this is the dilemma—the number of active cases outside sanatoria has also increased and out of proportion to the increase in cases.

At the close of 1945 the number of active cases of tuberculosis in the files of the State Board of Health totalled 6,102 against a total of 4,206 in 1942. The number of active cases outside sanatoria has jumped from 45 per cent in 1942 to 70 per cent in 1946.

In general, cases in the active file fall into two categories: those that are active, and those definitely tuberculous but of undetermined activity. A total of 4,344 cases in the file are definitely active, but 2,516 (58 per cent) of this number are not in a sanatorium. It is assumed that most of these 2,516 cases are under the care of private physicians; at any rate public health personnel are exerting their efforts to accomplish that objective.

Why bother me with these figures, you may ask. For a very good reason, doctor. In tuberculosis, as in many another public health problem, the practicing physician is the key to the solution. We have a feeling that if practicing physicians felt more keenly the urgency of hospitalizing tuberculosis cases, both for the sake of the patient and the community, there would be a great many more patients seeking sanatorium care.

Hospitalization Aids Recovery

Rest is the basic principle in the treatment of tuberculosis. Rest as applied to the tuberculosis patient has an entirely different meaning than when applied to other individuals. How can you be assured that when you prescribe even this simple prescription, "rest," the patient will take the "medicine" unless he be in a sanatorium where that basic essential can be provided? The answer, bluntly, is that you can't. Again, before it can be known whether any other type of treatment is necessary the patient must undergo a period of observation, in most cases. Where better to obtain this than in a sanatorium? Other studies such as sputum concentrates, gastrics, sedimentation tests, repeated x-rays, and comparison of films are best obtained within a sanatorium. Then if more treatment is indicated such as pneumothorax, phrenics, pneumoperitoneum, and thoracoplasty, where better can it be administered than in a sanatorium? A physician who gives the matter any thought we believe must fairly conclude that for the sake of the patient, sanatorium care is better.

Finally, but by no means least in importance, because you know the high communicability of the disease, you have a responsibility to the patient's family and to the whole community in seeing that his infection goes no farther. Is there a better means of assuring this protection than by isolating the patient in a sanatorium?

There's no substitute for the physician-patient relationship. What you, the physician, say to the tuberculosis patient regarding treatment and sanatorium care will do more to convince him to enter a sanatorium than will the same words, or ten times that many, spoken by any other person, be it the patient's relatives, public health nurse, local health officer, or district health officer. Obviously not every patient will be convinced by his physician of the necessity for sanatorium care, but we cannot believe that such will be the result with 2,516 patients.

Your efforts and support in this phase of the problem will be a long stride towards the eradication of tuberculosis in Wisconsin.—ALLAN FILEK, M. D., *Director, Local Health Services.*

* See The Wisconsin Medical Journal 44:891 (Sept.) 1945.

. . . . THE PRESIDENT'S PAGE . . . .

Slumbering Away

RIP VAN WINKLE, Irving's fiction character, slept for twenty years. But he did wake up! Many doctors, engrossed in their technical medical duties are slumbering away their economic and political rights and privileges. Do you question this statement? Let me quote some of the recent observations of men high in the profession who are not dreamers. This is from Harold Swanberg, B.S., M.D., F.A.C.P., editor of the Mississippi Valley Medical Journal:

"That many politicians, social workers and labor leaders are attempting to socialize medicine by means of government compulsory health insurance, there is no doubt. Every physician will freely admit that the advent of socialized medicine would greatly encroach on private medical practice. However, the threat of government compulsory health insurance and socialized medicine is not the only menace the private practitioner faces. From time to time we have attempted to point out the gradual encroachment of hospitals on the private practice of medicine. It appears that the private practitioner is slowly but surely getting in the proverbial position of being 'between the devil and the deep blue sea.' "

Nearly a year ago a past president of one of our largest state medical societies stated:

"Unless we are very careful, indeed, we are apt to find hospitals dictating the practice of medicine. The trend in that direction may have been unconscious and unintentional at first, but I think it is neither of those things now."

Recently a past-president of the Washington State Medical Society stated that the average practitioner faces two threats: governmental compulsory health insurance and medical practice controlled by hospitals. I quote part of his statement:

"During the past fifteen years, while physicians have been stirred by the prospects of socialized bureaucratic medicine, a far more insidious threat to private practice has materialized. This threat has been so close at hand and so subtle as to have almost passed unnoticed. Today the hospitals engage in practices that would have horrified the profession in the past. They collect the hospital and professional bill and pay the doctor according to an agreed schedule; they have staffs composed exclusively of salaried employees. Furthermore, the hospital administrators concede that the income earned by radiologists, pathologists and anaesthesiologists, is an important source of revenue to their institutions.

"The House of Delegates of the American Medical Association on numerous occasions has declared against the selling of medical services by hospitals; it has adopted a resolution requesting the American Hospital Association to withhold approval of the Blue Cross contracts which include medical services with hospital care. American Hospital Association officials declined to be quoted but indicated informally that they might merely ignore this request. These are unmistakable signs that, unless checked, the trend will continue to develop until the bulk of medical practice is carried on by hospitals using employed physicians. Without doubt the Blue Cross proposes to give medical services with or without the approval of the medical profession.

"The official publication of the American Hospital Association states: 'Diagnostic treatment and care of the ambulatory sick becomes increasingly the function of the hospital as the hospital develops into the center of community health activities.'

"We are now approaching the day when physicians will be merely a class of skilled laborers, readily hired and fired by the community health center. The average practitioner should decide whether it would be worse to have compulsory health insurance providing cash benefits for medical care under government control or medical practice controlled by the Blue Cross and Hospital Corporations, delivered by salaried doctor employees."

When you eventually stir out of your pleasant dreaming, doctor, and open your eyes to realities you may see a federal official pinning a number on your lapel and sticking a directive into your hand that will state how, when, where, and for what pay, you may practice your profession. Or, you may take a patient to a hospital and read a sign above the door saying: "Assorted Hospitals Service, Inc. announces that only its salaried staff will care for patients in this hospital." Or, you may find yourself faced with a combination of the two situations. It will be an unhappy awakening for you, doctor, when you do open your eyes to your plight and ask desperately what has become of the spirit of the Fourteenth Amendment to the Constitution of the United States.

P. R. Minahan

THE WISCONSIN MEDICAL JOURNAL

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« « « EDITORIALS » » »

Introducing Dr. Harrison H. Shoulders, the Guest Editorialist

HARRISON H. SHOULDERS

The transition from Speaker of the House of Delegates, to President-elect, and in July, to the office of President of the American Medical Association is in keeping with the active career of this distinguished man. Doctor Shoulders is a native of Tennessee. Following preliminary education at the Potter Bible College in Kentucky, Doctor Shoulders attended the medical department of the University of Nashville receiving the degree of Doctor of Medicine in 1909. He early became identified with organized medicine and public health, for a time as assistant secretary and executive officer of the Tennessee State Department of Health. Later, following postgraduate study in New York, and two years overseas service in the First World War, he returned to his native state. From 1930 to 1938, Doctor Shoulders served as a Delegate to the American Medical Association, in 1935 he became vice-speaker of the House and in 1938 was elected speaker, a position he held until his election as President-elect in 1945. He is certified as a member of the Founders Group of the American Board of Surgery, a fellow of the American College of Surgeons, on the medical teaching staff of Vanderbilt University Medical School, and was an organizer and first president of the Nashville Surgical Society.

Quick to understand, sharp and to the point in speech, a man of wide background, and possessing a charming personality, Doctor Shoulders has long impressed his colleagues with his sound judgment, and his ability to persuade others to his convictions. To the high office conferred on him by his professional colleagues, Doctor Shoulders carries with him their whole-hearted support in the trying days that are still ahead. And it is with a deep sense of gratitude that *The Wisconsin Medical Journal* presents the following editorial written particularly by Doctor Shoulders for the physicians of this state.

Progress in Medical Care Through Freedom of Action on the Part of Patients and Doctors

IN AN editorial by Senator Robert F. Wagner which appeared on these pages some issues back he said: "There is general agreement on the necessity for, and desirability of, a program for improving the health of our nation. Financial barriers to adequate medical care and the unequal distribution of doctors and hospitals as between urban and rural areas, and between prosperous and underprivileged communities, are reflected in the incidence of illness and disability, and in the Selective Service rejection rates.

"A health insurance program will go a long way towards correcting these conditions. Such a plan will enable the people to obtain all needed medical care through small, regular payments based on their earnings, and will give them security against catastrophic costs for which they cannot budget individually. It will encourage doctors to settle in rural areas, and communities to construct needed hospitals, by assuring adequate incomes and facilities for modern medical practice. It will benefit both patients and doctors.

"Propagandists against health insurance shout 'regimentation' of doctors and patients, 'political' and 'socialized' medicine, 'lowered standards,' and so on. But health insurance is *not* socialized medicine. Health insurance is simply a method of paying medical costs in advance. It is simply a method of assuring a person adequate medical care by eliminating the financial barrier which exists between the patient and the doctor."

The medical profession has been working at the job of improving the health of the people through all the period that this country has been a nation and with a success which is without a parallel in any other nation. The results are reflected in declining death rates and increased life expectancy. The death rate of the United States in 1944 reached the low level of 10.6 (per thousand). Life expectancy has increased from 34 years in 1879, to 65 years in 1945. The implication that medical care in the United States is of low quality is without foundation in fact.

The medical profession has stood for progress and has worked for sound progress, and the people of the United States have cooperated in this laudable endeavor on a voluntary basis. The medical profession still stands for sound progress in the prevention and cure of illness, and for financial aid to those unable to provide for themselves on such a basis as not to threaten their freedom.

The medical profession years ago sponsored legislation to create health departments clothed with the police powers of the state. This was done because individual doctors and individual patients could not protect themselves against certain diseases. The prevention of many diseases required the use of the police powers of the state. By the prudent use of these powers in the enforcement of laws and regulations to prevent the importation of disease, the spread of disease, and to correct the environmental conditions which produce disease, great good has been done. These departments, of course, were never created to administer individual medical care, nor have they been provided with the personnel and equipment necessary to carry on such activities.

No one dreamed that any members of these departments would ever support a measure to create a form of totalitarian medical care with them as administrators.

Hearings are now being conducted on the Wagner–Murray–Dingell bill. Its proponents allege it is insurance. It bears no resemblance to insurance as we know it. The last thirty odd pages of the bill provide for a mechanism by which medical care and medical education would become matters of *federal patronage* by the simple process of taxing the people in some way to create a huge federal fund to be expended for medical care and medical education. The federal administrator is empowered to contract for service. It is difficult to understand how anyone can refer to such a proposal as insurance. The people of this country are thoroughly insurance minded. They know that when they buy life insurance, disability insurance, fire insurance, and so on, they receive from the insurer a contract in which is stipulated the benefits that are to be received and the conditions under which the benefits are to be paid.

Under the Wagner–Murray–Dingell bill the people will receive whatever services the Surgeon General and his advisors determine they shall receive.

Preventive public health services would be available to all the counties in which the services are not now available, were it not for the policies followed in the distribution or allocation of federal funds that the Congress has already appropriated. These services should be available. The policies require that the county, regardless of its needs and ability, must match the fund on some basis. As a result of this policy, the money goes to counties which need no aid and fails to reach the counties which need aid and can't match the funds.

It has been variously estimated that from 300,000 to 500,000 employees would be required to carry out the provisions of the Wagner–Murray–Dingell bill. It was pointed out some years ago by the professor of Political Economy at Harvard University, that when the number of tax eaters has increased much further they will have the power to take over the government. These tax eaters acquire a vested interest in a job at public expense. Their political power can become overwhelming under a unified command. Witness the number of federal employees who have come forward to support the Wagner–Murray–Dingell bill.

The issue before the American people is simply this: Shall patients and doctors retain their freedom of judgment in the matter of medical care or shall these freedoms be surrendered to a federal bureaucracy? Shall freedom be given up in exchange for a promise for better things—a promise unsupported by facts born of experience?

H. H. Shoulders, M. D.

A BETTER APPROACH

It is noted with interest and approval that rural youth leaders are shifting the emphasis of 4-H health programs away from the "stock judging" method to one of evaluating health improvement and active participation in community health programs.

For many years the 4-H clubs in Wisconsin,* as in other states, have emphasized the quest for the "healthiest boy and girl" in the state. Candidates were judged on the soundness of teeth, perfection of posture, and other physical standards which are often as much or more determined by inheritance factors than attributes of sound health practices. Those responsible for the judging of candidates recognized that their findings had no valid basis for acclaiming a single boy and a single girl as the finest expressions of healthful living.

Beginning with the next period of 4-H club activity the 35,000 rural boys and girls in Wisconsin affiliated with club projects will participate in a health program which encourages individual health improvement as a means of attaining a high rating for the entire club. Club awards at the end of the year will be compiled on individual records of health examinations, immunizations, dental inspections, and specific health projects around the home or in the community.

State 4-H leaders are asking the cooperation of county societies through active sponsorship of awards to be made at the close of the year. Instead of decorative but stylized plaques the awards are to be in the form of recreation kits which will serve to promote the very health activities which are goals of the entire program.

Such enlightened modifications of health programs among rural youth should be encouraged. It is hoped that all county societies will support this attempt to make health programs among rural boys and girls more practical and meaningful.

SOMETHING TO THINK ABOUT

The *Journal* sometimes wonders if America's time-honored subject for the school debate—State's Rights—is not soon to be relegated to history along with the gold standard. Infiltration of federal influence and domination can be accomplished in more ways than by legislation which happens to meet constitutional approval by federal courts.

One of the newer methods is now being demonstrated in Wisconsin. A state agency has become responsible under federal law for the administration of a public assistance program, having for its purse an amount of federal aid equal to whatever is contributed for that purpose by the state itself.

So far, so good.

But here is something new. The *entire administrative payroll* is carried under the aegis of the federal government. Not a red cent comes out of the state's pocketbook. It is something to think about.

WHY THE GUEST EDITORIAL

And while the subject of medical economics is under discussion, the *Journal* wants to do a little "pointing with pride." In this issue there is a most valuable contribution from Dr. Harrison H. Shoulders. Recent issues have featured contributions written especially for the *Journal* by such state and national figures as Rev. A. J. Berens, medical regent of Marquette University; United States Senators Claude Pepper and Robert F. Wagner; Wisconsin's health officer, Dr. Carl N. Neupert; and many others.

And why has this become a policy of the *Journal?* Is it to flatter men, stir needless controversy, or to disturb the hearts of that profession which gives so much of itself that others may bear life and death most humanely? If any of these appear to be a basic consideration, the *Journal* has failed its obligations.

There is offered here a sincere attempt to awaken where it needs awakening that constant search for truth, the kind of truth that brings light to the farthest depths of the horizon. It is not in recriminations, nor in musings of bygone days, that the best of the future is found. It is given to no other group as it is given to the medical profession to be analytical and farsighted as well as courageous and generous. Such is of act as well as thought.

A SPEAKER'S REACTION

Many lay as well as professional organizations have sought the cooperation of the Society's office in providing a speaker to discuss current proposals to "socialize" medicine. After such a presentation, efforts are made to secure the speaker's own reactions relative to the group before which he spoke. Were they interested in the topic? Were they inquisitive? Did they seem to have prior information? What was their attitude generally? How did they feel as to voluntary efforts?

Reports, as might well be expected, have varied widely. But one of them is of real concern. A member of the profession who has been more than generous of his time in this effort indicates that in many localities the profession itself seems but little informed on these matters. Many physicians, he reports, even though active in local affairs, can only speak in broad terms of such measures as the Wagner–Murray–Dingell bill.

This causes the *Journal* to remind its readers that a loan packet is available from the State Society—a packet that contains a copy of the bill itself, as well as arguments for and against the measure. It is available on a moment's notice to any member of the State Medical Society.

* Wisconsin has fostered an active 4-H program for many years, with general practitioners in rural areas closely identified with the movement. It may interest those physicians who have worked most closely with 4-H leaders to know that the founder of the 4-H movement was the father of Dr. T. C. Erickson, neurosurgeon at Wisconsin General Hospital, Madison.

MEMO FOR FUTURE NOTE

There are many scarce commodities today. The condition is attributed to the war, or its inevitable aftermath. Some might be due to poor planning and inept execution. Medical publications and organizations continuously warned of the consequences in drafting the pre-medical student without regard to his educational status.

But the public health interests of the American people were not adversely affected solely by that policy. A national authority in the pharmacy field estimates that the nation's drug stores have an immediate minimum need of 8,000 more pharmacists. While the shortage was in the making, it is said, prior to the war, the drafting of potential students rendered the situation increasingly acute. It is said that despite the current increase in pharmacists' salaries to nearly double that of pre-war years, it has still been difficult to lure the retired elderly pharmacist back to the business. It is estimated that there are approximately 71,000 pharmacists now in the retail field, with some 53,000 establishments clamoring for their services.

This situation and that pertaining to the medical and dental fields indicates the need for careful evaluation of some of the nation's war-time draft practices in relation to the state of the nation as a whole. Right now is not too soon.

VENEREAL DISEASE UP

Is venereal disease increasing in Wisconsin—or is reporting of cases improving? For the first three months of 1946 more than four times as many cases of syphilis were reported to the State Board of Health as for the corresponding months last year. A slighter increase in gonorrhea is reported. The figures are revealing:

Cases Reported

	Syphilis		Gonorrhea	
	1945	1946	1945	1946
January	60	225	97	197
February	44	227	104	197
March	69	252	114	144
	173	704	315	538

During this three months' period in 1946 the Wisconsin Psychiatric Institute made 2,111 positive blood tests. Since many were repeat Wassermanns or noninfectious cases, the fact that 704 new cases of syphilis were reported for the period would seem to indicate very good reporting. For the first time it is becoming possible to estimate with some accuracy the real prevalence of syphilis in Wisconsin.

Much credit for the improvement must go to the new system of reporting inaugurated by the State Board of Health in March, 1945, upon recommendations of the Committee on Venereal Diseases of the State Medical Society. With each positive report returned to the physician the laboratory encloses a notice, a report blank, and a franked envelope. Apparently this system has been a long stride forward and indicates that if reporting is made convenient, physicians will cooperate.

There is less evidence that the legislation which became effective August 1, 1945, has contributed equally to better reporting. Under this amended law all laboratories making blood tests for syphilis or examinations for gonorrhea are required to report positive tests to the State Board of Health, with the name of the physician for whom the test was made. The three major laboratories, i.e., Wisconsin Psychiatric Institute, State Laboratory of Hygiene, and Milwaukee City Health Department, have consistently furnished weekly reports of tests made. However, a tabulation of all the other laboratories seems to indicate that (a) there is no infectious syphilis in the state, (b) all reports made by such laboratories are negative, or (c) many such laboratories do no serology. Of sixteen major approved laboratories, only five have furnished weekly reports of positive tests during three months of 1946. Of the remaining 235 hospitals, sanatoria, and related institutions, reports have been received from only six, spasmodically.

A tabulation of cases by county indicates some improvement in reporting. No syphilis was reported in eight counties from January through July, 1945 but from August (when the new law went into effect) through December only three counties show none.

Since laboratories are now required by law to show the name of the physician for whom positive tests were made, it would of course be possible for the State Board of Health to follow up each report to determine whether or not the physician had reported it. Far more desirable, however, would be a conscientious reporting of all cases by the physician just as for any other communicable disease. The purpose of this legislation is to find and bring under medical treatment all contacts. If the physician cannot get such contacts to his office for examination he may ask the State Board of Health for help in locating them. With full cooperation of practicing physicians, venereal disease in Wisconsin may yet be eradicated.—M. T.

COMPENSATION PANELS ISSUED IN JULY

The latter part of next month over 50,000 Wisconsin employers will receive copies of new Workman's Compensation Panels now being prepared in the Secretary's Office. The problem of compiling a full and accurate record of all physicians desiring participation has been intensified by the return or near-return of many members from the armed forces.

After August 1 all county societies are urged to check with employers to see that the panels are posted as requested by the State Society and the Industrial Commission.

Physicians in Service

For many months material in this section was carried under the title of "The Nation at War." With physicians still entering service, with many returning to reestablish themselves in civilian practice, and with many planning to continue in service for an indefinite time, it is the decision of the *Journal* to continue the section under a more timely title.

Returning Veterans

EDWIN B. GUTE

Lieutenant Commander Edwin B. Gute of Whitefish Bay, a veteran of World War I, who entered the Navy in World War II, March, 1943, received his discharge June 12, 1946, after serving within the country and two years overseas.

After several months at San Diego, California, and Bremerton, Washington, the doctor was transferred to Attu, Alaska, for fifteen months of service with the Fleet Air Wing. Upon completion of that duty, he was stationed at Okinawa, the Philippines, and in the Southwest Pacific.

Commander Gute wears ribbons from both wars: the Mexican Border Service 1916 ribbon, and the Victory ribbon (with four stars) from World War I; the Philippine Liberation, Asiatic–Pacific (with one star), and American Theater ribbons from World War II.

Planning to begin resident training July 1, at Columbia Hospital, Milwaukee, is **Lieutenant Frank H. Belfus**, who received his release from active duty with the Navy April 12.

The doctor entered service in July, 1943, and after a short time at Great Lakes, Illinois, was transferred to California to train with the Fleet Marine Force. Assigned to duty with the 1st Marine Parachute Regiment on New Caledonia in September, 1943, Lieutenant Belfus served with that regiment and with the Headquarters and Service Battalion of the 3d Amphibious Corps in the British Solomon Islands area. During that time he earned two campaign stars.

Upon returning to this country, he served at Camp Bradford, Virginia, and at Great Lakes, Illinois.

Lieutenant Commander Irving I. Cowan obtained his discharge from the Navy April 18, and has reestablished his office in Milwaukee. The doctor joined the armed forces in April, 1942, and served at San Diego, at U. S. Fleet Hospital No. 113 in San Francisco, and at the U. S. Naval Hospital in Oakland, California. He wears the American Theater ribbon.

Milwaukee practitioner, **Lieutenant Commander Vance L. Baker**, received his discharge from the Navy May 16, after two and one half years service, including twenty months overseas.

After serving at a base hospital in New Guinea from December, 1943, to February, 1944, Commander Baker was stationed on an LST during the Admiralty Island invasion. Shortly after that he returned to New Guinea for a while and then was transferred to the Philippines. Returning from overseas in July, 1945, he was sent to the Naval Air Station, Traverse City, Michigan. From October, 1945, until his discharge, he worked with Naval Recruiting in Milwaukee.

Commander Baker wears ribbons for the American and Philippine Theaters and has seven battle stars.

F. K. DEAN

Lieutenant Commander Frank K. Dean of Madison, has returned to the Dean Clinic following his recent release from active duty with the Navy Medical Corps. Commander Dean entered the service September 27, 1943, and served a year and a half in the Pacific Theater, participating in the campaigns at Tarawa, Saipan, Iwo Jima, the Marshall Islands, and the Philippines. His last year in service was spent at Great Lakes, Illinois, as chief medical officer of a section of the center. Doctor Dean wears the Asiatic–Pacific Theater ribbon with four battle stars, the Philippine Campaign ribbon with one battle star, and the American Theater ribbon.

Dr. George G. Drescher, formerly of Horicon, received his release, April 14, from active duty as assistant surgeon with the U. S. Public Health Service. After his entrance into service, January 1, 1943, he served in Denver and Englewood, Colorado, and Sandstone, Minnesota. Doctor Drescher's terminal leave expired June 2.

H. J. HANSEN

Upon completion of two and one half years of service with the Navy, **Dr. Horace J. Hansen,** recently received his discharge and has resumed his practice in Sheboygan Falls. Doctor Hansen entered the Navy November 19, 1943 and served at these places: San Diego, California; on board the USS Stermer Bay, an aircraft carrier; Pearl Harbor; the Central Pacific.

Lieutenant Commander Milan G. Helmbrecht who reported for duty with the Navy October 25, 1943, received his discharge April 28, 1946, after serving at Pearl Harbor. Upon completion of a refresher course at Wisconsin General Hospital, Madison, Doctor Helmbrecht plans to reopen his Elkhorn office about July 1.

Lieutenant Colonel Frank Hill of Wauwatosa, terminated his four years in the Medical Corps of the Army with a discharge, May 19. As a civilian, he is now with the Milwaukee County General Hospital.

Lieutenant Clayton L. Ingwell has returned to practice at Deerfield following his recent discharge from the Army Medical Corps, which he entered April 7, 1944.

Discharged in February, 1946, as a captain, **Dr. G. A. French** of Appleton, served twenty-four months overseas with the Army. In August, 1943, he entered the service, and four months later was sent to England, where he was assigned to the 96th General Hospital. From August, 1944, to November, 1945, he served with various medical battalions in France and Germany.

Captain French wears the European Theater ribbon with four stars for the battles of Northern France, Ardennes, Rhineland, and Central Germany, and was awarded the Bronze Star, the Silver Star, the Combat Medical Badge, the Special Unit Meritorious Service Plaque, and the Presidential Citation for the battalion.

Dr. Grant C. Stone returned to practice in Berlin recently, after several years in the Army. He entered service January 30, 1941, and served in this country and in Europe until his discharge November 14, 1945.

Doctor Grant is now associated with his wife, **Dr. Mildred Stone,** who carried on his professional business during his absence.

Major Richard A. Thayer returned to Beloit recently after receiving his discharge from the Army. Major Thayer entered the service in October, 1942, and for two years was stationed at various outposts in Alaska. "The life was pretty rugged in Alaska," Major Thayer said, "but when the weather was good the scenery was beautiful; but the weather wasn't good very often."

The doctor's last year in service he was assigned to the Vaughn General Hospital, Chicago. During his terminal leave, which ended April 8, he spent ten weeks at the Cook County Graduate School of Medicine. He has now resumed his practice.

Lieutenant Commander David J. Werner of Milwaukee, who entered the Navy in December, 1942, received his discharge April 5, 1946. Commander Werner served at the Navy Yard Dispensary in Washington, D. C., on board the USS Leonard Wood, and at the Navy Dependents Clinic in Chicago.

He wears these ribbons: American Theater; European Theater, with one bronze star; Asiatic Theater, with four bronze stars; Philippine Theater, with two bronze stars.

GEORGE PARKE, JR.

Richland Center physician, **Lieutenant Commander George Parke, Jr.,** received his discharge from the Navy Medical Corps April 11. Upon entering the service in September, 1942, the doctor was sent to Davisville, Rhode Island, for a month, following which he served at the U. S. Naval Hospital in Philadelphia, and the U. S. Naval Pre-flight School, Chapel Hill, North Carolina. In August, 1944, he went overseas and was stationed at Peleliu, Palau Islands, until December 27, 1945.

Commander Parke wears the American Theater ribbon and the Asiatic–Pacific ribbon with one battle star.

Milwaukee physician, **Lieutenant George J. Worm,** received his discharge January 3, after three and one half years in the Navy. After entering the service in August, 1942, Lieutenant Worm reported to San Diego for four months duty, and then to Long Beach, California. On January 26, 1943 he left for duty on the USS Republic in the Southwest Pacific. Returning to this country in February, 1945, the doctor served in Seattle, Washington, and at Great Lakes, Illinois, until his release.

Lieutenant Worm wears the American Defense and Asiatic Theater ribbons.

Captain Joseph J. Young, Appleton, was discharged from the Army January 6, upon completion of service in this country and overseas. Captain Young entered the service February 1, 1941, and was assigned to the Station Hospital, Camp Grant, Rockford, Illinois, for a year. He served with the Aviation Cadet Examining Board at Grand Rapids, Michigan for the following half year and then returned to Camp Grant.

In March, 1943, he reported to Atlanta, Georgia, and went overseas with the 4th Auxiliary Surgery Group of the 3rd Army.

Captain Young wears the American Defense and European Theater ribbons, and has five battle stars.

After two and one half years of duty with the Army, **Dr. Irving E. Schiek, Jr.,** of Rhinelander, received his discharge February 24. The doctor entered the service September 9, 1943, and served at various posts, including Carlisle Barracks, Pennsylvania; Atlanta, Georgia; and overseas.

After thirty-two months of service with the Navy, **Lieutenant Commander Paul N. Sowka** of Stevens Point, was discharged recently and has re-opened his practice.

Commander Sowka served in this country until May, 1945, when he went on duty with a Marine fighter plane squadron aboard a converted carrier in the Pacific Theater. Since October, 1945, when he returned from overseas, the doctor was stationed at Santa Barbara and El Toro, California.

Appleton physician and surgeon, Captain **Francis M. Hauch,** who entered the armed forces June 3, 1943, has recently been discharged and is opening his office in Appleton. He served at Carlisle Barracks, Pennsylvania, Camp Patrick Henry, Virginia, and overseas.

T. A. HELLER

After almost three and one half years in the Army, **Major Theodore A. Heller** of Milwaukee, received his discharge March 16. Upon entering the service in November, 1942, the doctor took basic training for a month at West Palm Beach, Florida, and then joined the Air Transport Command, serving at Camp Luna, New Mexico, until he was assigned to the Alaska Division in March, 1943. After finishing his service in Alaska and Canada, he returned to the country in September, 1945, and was stationed at Nashville, Tennessee, and Dallas, Texas with the Ferrying Division of the A.T.C. until his discharge.

He wears the American, Asiatic Theater ribbons.

JOSEPH PESSIN

Termination of service as a physician in the Army came May 8 for **Lieutenant Colonel Joseph Pessin** of Madison, former assistant professor in neuropsychiatry at the University of Wisconsin. Colonel Pessin, who entered service October 10, 1942, wears the Asiatic–Pacific Theater ribbon with two battle stars, the Philippine Liberation ribbon with one battle star, and the American Theater ribbon.

After receiving his release from active duty with the Army recently, **Lieutenant F. J. Rankin** resumed his private practice in Appleton. The doctor was stationed at Denver and overseas after his entrance into service December 16, 1943.

After five and one half years in the Army, **Lieutenant Colonel Mathias F. Regner,** formerly of Port Washington, received his discharge February 20.

Upon entering the armed forces November 5, 1940, the doctor served with the Wisconsin Induction Board in Milwaukee for several months. In February, 1941, he transferred to Randolph Field, Texas, to the School of Aviation Medicine. Before he went overseas in October, 1943, Colonel Regner was stationed with troop carrier units in Fairfield, Ohio; Sedalia, Missouri; and two towns in North Carolina. Overseas he served at Battesford and Exeter, England; Orbotello, Italy; and Rheims, Le Mans, and Chartres, France.

The doctor wears the American Defense and American Theater ribbons, and the ribbon of the European Theater of Operations with seven battle stars. He also holds the Bronze Star Medal.

A recently discharged Racine physician, Captain **John R. Nickelsen,** has been cited for meritorious achievement in the Northern Luzon campaign, and was awarded the Bronze Star Medal. Captain Nickelsen rendered outstanding service when his battalion, a part of the 32nd Division, was isolated by the enemy for almost a week. By serving nearly twenty-four hour duty for six consecutive days, his efforts saved the lives of critically wounded men. Brigadier General Robert B. McBride, Jr., commanding officer of the 32nd Infantry Division, said that Captain Nickelsen's services were invaluable during that period and his ability inspired great confidence in the personnel of the battalion.

Dr. Frank N. Pansch was recently discharged from the Navy, and has formed a partnership with **Dr. G. R. Anderson** in Neenah.

P. R. KUNDERT

Dr. Palmer R. Kundert, released from the Navy in January, has opened an office in the Tenney Building, Madison. Doctor Kundert, formerly located in Orlando, Florida, is practicing in Urology.

Graduated from Harvard Medical College in 1933, and licensed in Wisconsin the following year, the doctor entered the Navy in August, 1942. A lieutenant commander, he served twenty-two months in the Pacific theater as head of the department of Urology, Fleet Hospital No. 110, based in the Russell Islands.

Upon completion of over two years of active duty with the Navy Medical Corps, **Commander Robert E. McDonald** of Milwaukee, went on inactive status December 1, 1945.

Entering the Navy October 11, 1943, Commander McDonald served at Mare Island, California; on board the USS Lunga Point in the South Pacific area; at Headquarters, 13th Naval District, Seattle; on board the USS Deuel in the Central Pacific, and at the Naval Recruiting Station in Milwaukee.

Commander McDonald wears the American Defense ribbon and the Asiatic–Pacific Theater ribbon with two stars for the campaigns of New Guinea and Iwo Jima.

Lieutenant Colonel Mancel T. Mitchell, formerly of Eau Claire, received his discharge from service January 14. The doctor went on active duty with the Army in January, 1941, as a battalion surgeon at Fort Sam Houston, Texas. In December of that year he transferred to Denver, Colorado, and later served at Army Air Fields in Stamford, Greenville, and Victoria, Texas.

As a group flight surgeon, he went overseas in February, 1944, and saw service with the 9th Air Force based in England. A year later he was made chief of section, general surgery, with the 221st and 189th General Hospitals in France.

Colonel Mitchell has resumed practice in Minneapolis and is clinical assistant professor at the University of Minnesota Medical School.

For exceptional valor and self-sacrifice under action, **Captain Lawrence H. Feiman**, Milwaukee, recently discharged from the Army Medical Corps, has been awarded the Military Valor Cross by the Italian government. Captain Feiman had previously been given the Legion of Merit by the United States Army for performances in five campaigns in Italy. With plans to become an eye specialist, the doctor is taking postgraduate work at the University of Wisconsin Medical School, Madison.

Lieutenant Commander Donald F. Rikkers of Milwaukee, received his discharge from the Navy April 6. Commander Rikkers' first post, after entering the Navy in September, 1943, was the Navy Yard Dispensary in Washington, D. C. He served also at San Bruno and Shoemaker, California, before joining the 85th Naval Construction Battalion in the New Hebrides Islands, December 27, 1944. From September, 1945, until his return to this country in February, 1946, the doctor was with an advance base dispensary on New Caledonia, and also served on board the USS Bougainville.

Commander Rikkers wears the Asiatic–Pacific Theater and American Defense ribbons.

After forty-one months with the Navy, **Lieutenant Kenneth J. Winters** received his discharge May 12, and obtained an association with **Dr. F. R. Janney** and **Dr. Katherine H. Baird** in offices in Wauwatosa. Lieutenant Winters served with the Navy in Oakland, California; Miami, Florida; and overseas.

After receiving his discharge from service February 21, **Captain Jerome F. Paulson** resumed his medical practice in Sun Prairie. Of his twenty-eight months in service, twenty-four were spent overseas in New Guinea, the Philippines, Australia, and Japan.

MARVIN A. JOCHIMSEN

Milwaukee physician, **Lieutenant M. A. Jochimsen**, received his discharge April 16, after three years and several months in the Navy. He rendered service at Navy centers in Norfolk and Portsmouth, Virginia, New Orleans, and Chicago. From April, 1944 to November, 1945, Lieutenant Jochimsen served overseas on the destroyer tender, USS Yosemite.

Lieutenant Jochimsen wears the American Theater, Asiatic–Pacific Theater, and Philippine Liberation ribbons.

Colonel John S. Wier, Fond du Lac practitioner, received his discharge from the Army February 4. Colonel Wier began his Army duty February 11, 1941, and became commanding officer of the 48th Armored Medical Battalion, 2d Armored Division. He served in this country for a year and then went overseas to Africa and Sicily. From 1943 to 1944 he was in England, and served the next year in France, Belgium, Holland, and Germany.

Colonel Wier wears the American, and European–African Theater ribbons, and has campaign stars

for Sicily, Normandy, Northern France, Rhineland, Ardennes and Continental Germany. He also holds these awards: Legion of Merit, Silver Star, Bronze Star with oak leaf cluster, Belgian Fourragere, Russian Medal for Battle Participation.

J. P. SKIBBA

Dr. Joseph P. Skibba, former Kaukauna physician, recently discharged from the Navy, has opened an office in Appleton, limiting his practice to Urology.

As senior surgeon on the surgical team of LST 171, the doctor, then Lieutenant Commander Skibba, participated in two invasions, those of Cebu, in the Philippines, and Tarakan, Borneo.

The artillery fire at Cebu was the most difficult action, the doctor said. "Our LST was beached, and we were under the easy range of Japanese artillery and mortar fire from the hills. This was worse than the kamikaze attacks during our approach of the Philippines."

During his two years in the Navy, Doctor Skibba also served as urologist at the Naval Hospital, Oceanside, California, and in the department of urology of the naval hospital at Great Lakes, Ill.

Recent Releases From Service*

Physicians and Location	Date Discharged
Babbitz, A. L., Milwaukee	March, 1946
Barnstein, Norman, Sun Prairie	May, 1946
Boxer, L. M. Milwaukee	June, 1946
Campbell, P. E., Waukesha	March, 1946
Clark, D. M., Beloit	June, 1946
Collopy, P. J., Milwaukee	February, 1946
Cowan, I. I., Milwaukee	April, 1946
Cummings, E. F., Oshkosh	June, 1946
Dana, R. L., Fond du Lac	April, 1946
Drescher, G. G., Beaver Dam	June, 1946
Gantz, H. A., Waukesha	January, 1946
Gilbertsen, C. R., Janesville	May, 1946
Green, D. M., Wausau	March, 1946
Gute, E. B., Milwaukee	June, 1946
Hargarten, L. W., Milwaukee	April, 1946
Hauch, F. M., Kaukauna	May, 1946
Heinan, F. C., West Allis	April, 1946
Herzog, P. S., Kenosha	December, 1945
Ihle, C. M., Eau Claire	May, 1946
Jochimsen, M. A., Milwaukee	April, 1946
Johnson, J. H., Milwaukee	March, 1946
Keenan, L. J., Fond du Lac	February, 1946
Kief H. J., St. Cloud	February, 1946
Kinsey, J. L., Milwaukee	April, 1946
Kleinpell, W. C., Kenosha	February, 1946
MacGregor, J. W., Portage	February, 1946
Mannis, Harry, Sparta	April, 1946
Pawsat, E. H., Fond du Lac	April, 1946
Pessin, Joseph, Madison	May, 1946
Picotte, L. W., Chippewa Falls	January, 1946
Polacheck, W. S., Milwaukee	March, 1946
Rauen, L. M., Kenosha	February, 1946
Rohde, E. P., Merrill	June, 1946
Rothman, L. E., Milwaukee	January, 1946
Rueckert, R. R., Portage	January, 1946
Saxe, J. J., Portage	March, 1946
Schwartz, H. L., Kenosha	June, 1946
Shannon, R. C., Milwaukee	April, 1946
Shapiro, Harry, Adams	May, 1946
Simones, J. J., La Crosse	April, 1946
Sweet, S. J., Milwaukee	March, 1946
Thayer, R. A., Beloit	April, 1946
Theobald, P. B., Oconomowoc	May, 1946
Twohig, G. J., Kiel	February, 1946
Verdone, A. J., Milwaukee	April, 1946
Werra, B. J., Waukesha	April, 1946
Wilkinson, D. C., Oconomowoc	February, 1946
Wilkinson, P. M., Oconomowoc	January, 1946
Wirthwein, Carlton, Milwaukee	March, 1946
Wood, C. A., Waukesha	November, 1945
Wright, R. S., Racine	April, 1946
Zantow, F. E., Madison	June, 1946

* Members of the State Society listed in boldface.

HAS YOUR DATA SHEET BEEN SENT IN?

The Committee on War Records is planning the publication of an elaborate brochure, with pictures and data on the military service of all members. If your picture has not been run in the *Journal*, as a feature of the Military Notes section, please send us a gloss print for your individual folder in the files of the Secretary's Office. Also, the War Records Committee needs information on your military record: when and where inducted, change of rank, where served, special awards, and date and place of discharge. Please see that we have this information, so your picture and military record can be included in the brochure being planned. Address your communications to Robert W. Blumenthal, M. D., Chairman, Committee on War Records, State Medical Society, 917 Tenney Building, Madison 3, Wisconsin.

VETERAN PHYSICIANS' EXCHANGE

This page will be devoted to a classified section, open without charge to: (a) veteran members desiring location and (b) other members having professional openings suitable for men returning from military service.

LOCATIONS WANTED

DESIRE GENERAL PRACTICE in town 5,000–25,000 anywhere in Wisconsin with good hospital facilities. Have much of own medical equipment from previous general practice. Over 3 years service in U. S. Public Health Service with wide variety of general practice especially in internal medicine, general surgery, psychiatry, and eye work, especially refractions. Must have housing for wife and three children. Would consider partnership with older doctor who does own general surgery. Would also consider joining clinic. Address No. 112 in care of the Journal.

LOCATION WANTED: I have had a limited experience in general surgery, internship and residency. Experience as surgeon in native hospital while in service. Desire location with ample training facilities to enable eventual board application, assisting reputable surgeon, or general practice with surgical opportunity. Address No. 122 in care of the Journal.

ASSOCIATION WANTED: Veteran physician with 4½ years postgraduate training, primarily in surgery, in excellent institutions, having completed 5 years active naval service, intending to take the examinations for the American Board of Surgery, desires an association with an established group or surgeon. Will appear for personal interview promptly. Address No. 124 in care of the Journal.

ASSISTANCE WANTED

WANTED: Location or association with older physician or group in Middlewest community of 5,000–50,000. I am 33, gentile, married, graduate of Class A school, with 2½ years surgical residency, and 2½ years surgical experience in Army hospitals. Letters of reference on request. Consider partnership and prefer general practice with opportunity to do surgery. Permanent location desirable. Available about July 1. Can arrange personal interview. Address No. 126 in care of the Journal.

LOCATION WANTED: I would like to locate in a small or medium-sized town. Have had 3 years' training at Milwaukee County General Hospital and 4 years of general practice in Milwaukee. Address No. 128 in care of the Journal.

LOCUM TENENS WANTED: A capable physician desires locum tenens for a short or long period. Will not compete afterwards. Licensed in Wisconsin. References furnished. Address No. 125 in care of the Journal.

SUBURBAN PRACTICE: Unusual opportunities in La Crosse. Office space available and help in contacts. See ad on page 646 for details.

ASSISTANT WANTED: Young man well trained in obstetrics and surgery for assistantship with busy general practitioner located in the heart of Milwaukee. Office well equipped and staffed. Association on increasing percentage, leading to partnership. Address No. 127 in care of the Journal.

ASSOCIATE DESIRED: To do internal medicine and pediatrics. Also required to assist in major surgery. Excellent opportunity in a good community which has a well-equipped 60-bed hospital. Applicants must have had postgraduate training in internal medicine or pediatrics. Address No. 115 in care of the Journal.

WANTED: Assistant interested in general practice and future association as partner. $300 per month and commission to start. Prefer single, Protestant, young returning serviceman or recent graduate. Address No. 123 in care of the Journal.

VETERAN PHYSICIANS: This is a strategic time to enter public health. State Board of Health has 2 openings for physicians with executive ability as directors of the tuberculosis and venereal disease divisions. Salary $4,800 to $5,400 plus necessary traveling expenses, Madison headquarters. 5 district health officers also needed. If you were under 40 when entering the armed services and can otherwise qualify, write Dr. Carl N. Neupert, State Health Officer, Madison 2, Wisconsin.

WANTED: Staff physician at sanatorium approved for tuberculosis residency. Beginning salary $250–$300, less modest maintenance deduction. One position open July 1, another probable the last of March. Wisconsin licensure required. Person must have good professional and personal qualities. Write Superintendent, Wisconsin State Sanatorium, Statesan, Wisconsin.

For additional classified advertisements, see the Physicians' Exchange, page 646

HAVE YOU RESERVED YOUR ROOM?

Milwaukee hotels report increasing difficulty to reserve rooms on "last minute" calls. If you have not already done so, make your reservations for accommodations to cover the 1946 Annual Meeting.

The House of Delegates convenes on Sunday, October 6, so all delegates, Councilors, and others who desire to attend the opening session of the House should reserve their rooms starting on Sunday.

Scientific sessions will be held on Monday, Tuesday, and Wednesday, October 7–8–9. The House of Delegates and sessions involving meal service will be held at the Hotel Schroeder.

Looking at Sickness Insurance Abroad

By J. G. CROWNHART

Just prior to his death in Cleveland in 1941, J. G. Crownhart, Secretary of the State Medical Society of Wisconsin, addressed the Health and Accident Underwriters Conference in Chicago on "Looking at Sickness Insurance Abroad." With the current hearings and discussion on the Wagner–Murray–Dingell legislation and the whole subject of compulsory sickness insurance, it seems again timely to present Mr. Crownhart's paper in The Wisconsin Medical Journal. For the convenience of the reader, the whole paper was published in the July, 1941, issue of the Journal. It will be reprinted in installments in current issues of the Journal of 1946, beginning with the June issue and continuing through the October issue.

FOR the second time within a quarter of a century, we are living in a period wherein there is an announced advocacy on the part of some for statewide, preferably federally directed, systems of compulsory sickness insurance. The first period of advocacy may be said to have started about the time of the first compensation laws of 1911 and ended unsuccessfully with the entrance of the United States into the World War of 1917–1918. This current second drive may have been envisioned in the establishment of the Committee on the Cost of Medical Care in 1927; subsequent high lights have been its majority report, successive recommendations of the President's Committee on Economic Security, the so-called Interdepartmental Committee on Economic Security with its National Health Conference sounding board of 1938, and continuously, publications, surveys, edicts, and pronouncements through all of which runs the note of the immediate need for this form of government-operated compulsory insurance.

It was Dante who said "give light and the people will find the way." His expression of the democratic way of life today, as never before, needs to be applied to this proposal so often labeled as one for "health insurance."

Cognizant that low price is not of necessity synonymous with value, or change with progress, it is needful that if our social progress is to be progress in fact, we must examine before we purchase. Legislation may not be said to be experimental in its character if it establishes insurance contracts with millions of our citizens with millions of dollars paid annually into a vast governmental administrative system. Even a casual study of the world's economic legislative history shows beyond question that such legislation is repealable only in theory. Its passage establishes too many contractual relationships and too large an administrative staff to make its repeal more than a remote possibility.

Let us then examine what it is that some advocates would have our citizenry purchase. Fortunately we have the opportunity to examine it out of experience, for "compulsory health insurance" is not new,—first established in Germany in 1883, it is well along in middle life.

"The Brilliant Idea"

Rubinow in his book "The Quest for Security" well points out that giving this mechanism the title "health insurance" is to use a gilded wrapping to hide the contents. "The system in its application to losses resulting from sickness is properly known throughout Europe as 'sickness insurance,'" says Rubinow.

"Lloyd George, the author of the British system, clever politician that he was and still is," continues Rubinow, "struck upon the brilliant idea that the term 'health insurance,' which in some subtle way conveys the impression of accomplishing something it really cannot and does not undertake to accomplish, would make the proposal more popular; and the American movement some two decades ago adopted the idea from Lloyd George."

Now let us turn to a firsthand study of the operation of compulsory sickness insurance laws abroad. Regardless of what country is visited and regardless of wide variations in wordings of specific laws, at the end of the study one is deeply impressed that certain principles are found in operation wherever this law is enacted and these are inherent to the legislation and not susceptible to elimination through amendatory legislation.

Like all compulsory social insurance, compulsory sickness insurance is financed by compulsory paycheck deductions, together with a pay-roll tax paid by the employer and added to the cost of his commodity or service price, and sometimes aided by a state or federal appropriation. Where state or federal aids are a portion of the finances of the system they tend to decrease, over a period of years, in either amount or proportion until relatively they are insignificant as a source of financial support. In my own state of Wisconsin a measure for compulsory sickness insurance, now in its third session before the legislature, calls for a 2 per cent tax on every pay check of those covered, to be met by a 2 per cent tax on the pay roll paid through the employer. This amount is to finance sickness care only and fails to raise the revenues for what in Europe is by far the more important part of sickness insurance legislation,—a rate of compensation

(Continued on page 618)

The "SMOOTHAGE" regimen in the treatment of constipation

A rounded teaspoonful of Metamucil stirred into a glass of water, milk or fruit juice, three times a day, provides the soft, mucilaginous bulk which is desirable for natural elimination. Metamucil contains no roughage, no oils, no chemical irritants.

Metamucil is the highly purified, nonirritating extract of the seed of the psyllium, Plantago ovata (50%), combined with anhydrous dextrose (50%). It mixes readily with liquids, is palatable, easy to take.

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to be paid after a short waiting period to meet some part of wage loss. This is rarely, however, more than 50 per cent of the basic wage.

Two Separate Functions

Thus compulsory sickness insurance legislation normally comprehends two separate functions: (a) provision for caring for the sickness needs of the covered person and generally of his dependents, and (b) a wage loss compensation to cover periods of loss during illness of the wage earner. Substantially all systems place a limit of twenty-six weeks on the benefit period and establish a waiting period of three days or more before cash wage loss benefits begin. Because in an insurance system so large in its coverage, numbers of individuals will have disabling illness beyond a twenty-six weeks' period, practically all systems have as an integral part, or as accompanying legislation, an insurance for invalidity. This invalidity insurance, for a smaller premium, attempts to cover the sickness care required for the illness that extends beyond the twenty-six weeks' period covered by sickness insurance proper.

Furthermore, it should be clearly understood at the outset that compulsory sickness insurance in the United States could at its best cover only those who are employed on wages or salary. Under all proposals made to date that we have examined, substantially the entire farm population has been excluded for unless the system is federally operated through the sale of tax stamps by each post office and rural carrier, it becomes far too expensive to endeavor to make tax collections in any other way than by the employer of groups acting in that capacity for the government. The further difficulty in estimating the income of large groups of our rural population in terms of exact dollars upon which the tax can be levied is a further barrier so that when we speak of compulsory sickness insurance as it would actually exist in the United States, we must not think of it as a system whose benefits, whatever they may be, would to any considerable extent reach beyond the wage and salary earner in our population. This is a large percentage in many states, but is very far from a universal coverage system, excluding as it must, not only the farmer but the individual entrepreneur, the domestic servant, the unemployed, those on relief, the aged, and numerous other classes.

(To be continued)

Letters to the Editor

THE VIEWS OF ANESTHESIOLOGY

March 18, 1946

Dr. P. R. Minahan
Green Bay, Wisconsin

Dear Doctor Minahan: After reading your "President's Page" certain thoughts came to mind. Would it be well for the State Society to insist on certain rights of the profession?

I have put some thoughts on the enclosed pages, related to the matter of anesthesia. Would it not be a good follow up to your expressed thoughts to—Pass a resolution in the House of Delegates: (1) condemning dominance and dictation of the practice of anesthesia by hospital management, or (2) condemning the exploitation of anesthesia through charging more for service than is spent for that purpose, or (3) recommending that the staff of each hospital be allowed to determine how the service of anesthesia shall be accomplished.

Perhaps it is not my concern but the specific example of what you imply in your "page" is so glaring regarding anesthesia in our state that it seems worth considering as a beginning in fighting abuses.

Sincerely,

(Signed) Ralph Waters, M. D.
Department of Anesthesia,
University of Wisconsin
Medical School

RMW:vmp

P. S. Just as I was signing this, a letter came from an anesthetist in another state, but it so well illustrates what is happening that I'd like to quote from it. This man left a good practice in anesthesia to enter military service four years ago. In service, he met two surgeons from a town in another state and they agreed among themselves that he ought to join them when they all got out of service. He wrote to me some weeks ago that he had his license fixed up in the other state and was moving his family at once. Now he writes:

> "I thought I had foreseen everything before I went out there . . . but after arrival found I was unable to get an appointment to the anesthesia staff of the only good hospital in town . . . The sister in charge refused me a place on the staff since that would mean her anesthetic nurses would have less to do and therefore the hospital would make less money in their practice of medicine. The surgeons at the Clinic were unable to get her to change her decision. They are handicapped, as unless they obey orders, they soon find they are unable to get their patients admitted. There are two other small second rate hospitals there. The surgeons urged me to stick around for a few months till the situation would be corrected, but I can't live on climate alone. So that's that—just another trick that fate plays on one."

(Continued on page 620)

Protein a problem?

Use one of these Special Infant Foods

Altered Protein

HYPO-ALLERGIC* WHOLE MILK

Particularly suited for infants and children allergic to cow's milk protein, Hypo-Allergic Milk has been rendered less allergenic by means of prolonged thermal processing. When reconstituted with water it is used in the same proportion as whole cows' milk.

POWDER—1 lb. tins **LIQUID 14½ oz. tins**

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PROTEIN S-M-A* (Acidulated)

The easily digested curd and liberal vitamin content makes Protein S-M-A a valuable aid in the management of premature and undernourished newborn infants. Also indicated in infant diarrhea and other conditions where a high protein intake is required.

POWDER—8 oz. tins

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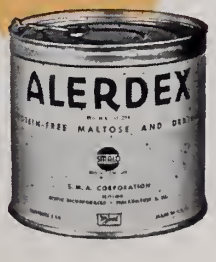

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S. M. A. DIVISION

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(Continued from page 618)

Is it right for us to permit hospitals thus to dictate to us how we shall practice?

Among the many anomalous situations which exist in medical practice that of the specialty of anesthesiology is notable in our state. Numerous doctors are returning from military service with a new appreciation of the importance of the service which can be offered by the anesthesiologist. Some of these are surgeons who, in military service, have had the help of physicians especially trained in anesthesia and are therefore accustomed to depend upon them. Others are former medical officers who received training and experience in anesthesiology while on active duty. And what prospect of applying their knowledge and skill in practicing anesthesiology in the hospitals of our state do these men encounter?

Among the staff members of nearly all our institutions are surgeons who appreciate and would welcome the help of the anesthesiologist. It is regrettable that no such cordiality is shown by the management of many hospitals. Institutions which actually forbid the administration of anesthetics by physicians are not uncommon. Others while not barring the doctor entirely, discourage him in the practice by charging the patient for this service whether the physician or a hospital employee actually officiates.

This corporate practice of medicine by hospital managements is a matter which deserves consideration by our Society at this time. Not only do we owe consideration to our fellow physicians who desire to practice anesthesiology, but it is also our responsibility to see that the best possible service is made available to our patients.

From the viewpoint of the hospital administration, it is desirable to increase the income of the institution by all legitimate means. Have the physicians who constitute the staff of our hospitals failed in making certain things clear to hospital management; first, that there is a service in modern anesthesiology which can only be rendered by especially competent physicians; second, that such service cannot be rendered competently or legitimately by technicians; and third, that economic exploitation of such service by the hospital is unfair to the physician who wishes to be an anesthetist, to the surgeon who desires his help, and to the patient whose welfare should be the interest of us all?

Hospitals, like doctors, exist to serve patients as safely and efficiently as possible. It may be the duty of the professional staff of every hospital to explain to the management of the institution in which they work the ethical implications of the customs in current practice. But is it not likely that a resolution passed by our House of Delegates might lend strength to their argument? Long ago it has been said, "The medical profession has the protection of court decisions holding that the license to practice is a 'property right' under the constitution. Is the profession prepared to sacrifice this protection by delegating the disposal of this 'property right' to the 'supervised' or 'corporation' practice of medicine? 'Supervised' technician anesthesia is the first big inroad of socialized medicine on the economic level of technician pay and standards. It also means the 'corporation' practice of medicine by hospital associations under lay control . . . If the 'property right' to practice medicine is not upheld . . . and safeguarded by the profession, the socialization and corporation practice of radiology, pathology, and anesthesia will be the future fate staring all other specialists, including surgeons, in the face."

Perhaps we, the physicians of Wisconsin, have failed to appreciate certain unfortunate and dangerous practices which have grown up in our midst. It may be that an analysis at this time will reveal ways in which we can guarantee better service to our patients. At the same time we may help to solve some of the problems of rehabilitation and readjustment to peacetime practice which now confronts many members of our Society. A situation which permits hospital management to discourage or even prevent physicians from practicing anesthesiology is one that demands the attention of the Society.

★

Appleton	WHBY	1230 kc.	Saturday	11:15 a. m.
Ashland	WATW	1400	Saturday	8:15 a. m.
Eau Claire	WEAU	790	Wednesday	4:15 p. m.
Green Bay	WTAQ	1360	Friday	3:45 p. m.
Ironwood, Mich.	WJMS	1450	Saturday	8:15 a. m.
La Crosse	WKBH	1410	Thursday	3:00 p. m.
Madison	WIBA	1310	Saturday	10:00 a. m.
Manitowoc	WOMT	1240	Saturday	4:30 p. m.
Marinette	WMAM	570	Monday	4:00 p. m.
Medford	WIGM	1490	Friday	11:15 a. m.
Milwaukee	WEMP	1340	Saturday	11:30 a. m.
Rice Lake	WJMC	1240	Monday	3:30 p. m.
Stevens Point	WLBL	930	Monday	11:30 a. m.

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Society Proceedings

Brown—Kewaunee—Door

The Beaumont Hotel in Green Bay was the meeting place for the Brown–Kewaunee–Door County Medical Society, May 9, when Dr. S. C. Cullen, associate professor of surgery (anesthesiology) at the University of Iowa, was guest speaker. A recognized authority on the use of curare, Doctor Cullen's speech was titled, "The Rational Use of Curare as an Adjunct to Inhalation Anesthesia."

Eau Claire—Dunn—Pepin

Meeting at the Elks Club in Eau Claire, May 6, the Eau Claire–Dunn–Pepin Medical Society heard *Dr. Anthony R. Curreri* of the department of surgery, University of Wisconsin, speak on the subject "Recent Trends in Thoracic Surgery."

Fond du Lac

Dr. John D. Owen of Milwaukee, specialist in obstetrics and gynecology, gave a practical lecture, illustrated with slides, on the subject of abnormal vaginal bleeding, at the April 25 meeting of the Fond du Lac County Medical Society. The Hotel Retlaw in Green Bay was the meeting place.

Jefferson

The Jefferson County Medical Society members met at the Forest Lawn Sanitarium, Jefferson, the evening of April 25 to hear *Dr. Andrew L. Banyai* read his paper entitled, "Chronic Non-tuberculous Infectious Diseases of the Lung." Doctor Banyai is associate clinical professor of medicine at Marquette University Medical School in Milwaukee.

La Crosse

The La Crosse County Medical Society's dinner meeting, May 14, was held at the Stoddard Hotel, La Crosse. The speaker of the evening was Dr. E. H. Rynearson of the Mayo Clinic, whose subject was "Endocrinology."

Milwaukee

The Medical Society of Milwaukee County, meeting at the Athletic Club, Milwaukee, May 10, heard *Dr. James P. Conway* of that city talk on the history of child welfare in Milwaukee County.

Outagamie

Members of the Outagamie County and Winnebago County Medical Societies held a joint meeting at the Valley Inn, Neenah, April 18.

"Common Injuries of the Urinary Tract, Their Recognition and Management" was the subject of the speech given by *Dr. James C. Sargent* of Milwaukee, who was recently discharged from the United States Navy Medical Corps.

Those present at the May 16 meeting of the Outagamie County Medical Society held at the Conway Hotel in Appleton, heard Dr. Harold P. Rusch, director of cancer research at McArdle Memorial Laboratory, Madison, speak on "Recent Advances in Cancer Research."

Pierce—St. Croix

A testimonial dinner honoring *Dr. Charles A. Dawson* was given by the Pierce–St. Croix County Medical Society May 8, at the White Pine Inn at Bayport, Minnesota.

Sheboygan

The Sheboygan Memorial Hospital was the scene of the Sheboygan County Medical Society meeting April 25. *Dr. Herman W. Wirka* of the Wisconsin General Hospital, Madison, gave a speech entitled, "Disorders of the Hips."

Walworth

Meeting at the Hotel Geneva, May 9, the Walworth County Medical Society heard *Dr. John W. Harris*, professor of obstetrics and gynecology at the University of Wisconsin Medical School, Madison, speak on "Recent Advances in Gynecology."

Washington—Ozaukee

At a testimonial dinner in Newberg, April 25, the Washington–Ozaukee County Medical Society honored *Dr. Herman Weber* on the fiftieth anniversary of his admission to the practice of medicine.

The doctor began as a druggist in Milwaukee in 1884, and then went to the Wisconsin College of Physicians and Surgeons. After a year of practice in Milwaukee, he moved to Newberg.

Dr. A. H. Heidner of West Bend, was master of ceremonies for the affair, at which fifteen doctors from Washington and Ozaukee counties attended, including: *Drs. T. D. Elbe* of Thiensville, *C. A. Balkwill* and R. F. Swanson of Grafton, *P. B. Blanchard*, *H. M. Katz*, and *O. J. Hurth* of Cedarburg.

Waukesha

The town of Statesan was the place selected by the Waukesha County Medical Society for its March 6 meeting. *Dr. R. H. Schmidt Jr.* and staff members of the Wisconsin State Sanatorium read papers on the subject of tuberculosis.

The April 3 meeting of the society was held at the Waukesha Memorial Hospital. The speech of the evening, titled "Treatment of Varicose Veins," was given by *Dr. Conde Conroy* of Milwaukee.

Speaking on "Injuries to the Small Bones," *Dr. James Regan* of Milwaukee, entertained the members at their May 8 meeting.

Subject to change without notice

You can assure women who seek to avoid the nervous tension, emotional imbalance and mental depression of the menopause that modern estrogenic therapy brings symptomatic relief in many cases without undue pain or waste of time. When Abbott's Estrone Aqueous Suspension is used, a few injections are sufficient in many instances to keep the patient in comfort for weeks. Clinical experiments have shown that out of 44 women who received three weekly treatments, 43 experienced relief for three to sixteen weeks.[1] As Estrone Aqueous Suspension is prepared in an aqueous menstruum, it can be administered to women who are sensitive to the oils commonly used in other estrone products. You may obtain Estrone Aqueous Suspension through your pharmacy in 1-cc. ampoules containing 2.0 mg. of pure crystalline estrone.

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1. Freed, S. C., and Greenhill, J. P. (1941), J. Clin. Endocrinol., 1:983, December.

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Winnebago

Meeting at the Athearn Hotel, Oshkosh, the members of the Winnebago County Medical Society were hosts to the Dental Society, May 2. Following a talk and movie, "Oral Surgery and Fractures of the Jaw," given by Major Cole Logsdon of Hines General Hospital, Hines, Illinois, a discussion was held, led by Dr. R. F. Schoenwetter of Oshkosh.

International College of Surgeons

Four pioneer Wisconsin surgeons, all over 80 years old, who have practiced in the state for over fifty-five years, were honored by the International College of Surgeons, Wisconsin Chapter, at a testimonial dinner in the University Club of Milwaukee, May 15. They were:

Dr. Thomas W. Nuzum of Janesville, co-founder of the Pember–Nuzum Clinic, who graduated from Rush Medical College, Chicago, sixty-one years ago.

Dr. William E. Ground of Superior, who, sixty-five years ago, graduated from the Missouri Medical College in St. Louis.

Dr. John M. Dodd of Ashland (in absentia), former president of the State Medical Society of Wisconsin, and long a member of the state board of medical examiners, who graduated from Starling Medical College, Ohio, fifty-seven years ago.

Dr. George Van Ingen Brown of Milwaukee, a noted plastic surgeon and an 1895 graduate of Milwaukee Medical College.

Introduction of the guest of honor, Dr. Curtis Lee Hall, clinical professor of surgery at George Washington University, and president-elect of the United States Chapter of the International College of Surgeons, was made by *Dr. Samuel G. Higgins*, Wisconsin Chapter president.

Tri-County Medical Society

Dr. E. R. Schmidt of the Wisconsin General Hospital in Madison, and a native of Arcadia, was guest speaker at the April 18 meeting of the Tri-County Medical Society held at the Annex Hotel, Arcadia. His address was on the subject of surgery. *Dr. R. L. Alvarez* of Galesville, presided in the absence of *Dr. J. C. Tyvand*, president of the society.

Among those present were: *Drs. F. T. Weber, Elizabeth Comstock, B. R. Walske*, and *B. C. Dockendorff*, Arcadia; Drs. S. W. Simonson and *R. M. Rogers*, Whitehall; *Dr. C. O. Rogne*, Ettrick; *Dr. H. A. Jegi*, Galesville; *Dr. F. C. Skemp*, Fountain City; *Dr. K. F. Manz*, Black River Falls; *Dr. E. A. Meili*, Cochrane.

Milwaukee Academy of Medicine

Meeting at the University Club of Milwaukee, May 21, members of the Milwaukee Academy of Medicine held a dinner, followed by a business meeting and a scientific program. Mr. Jack T. Wilson, physicist with Allis–Chalmers Manufacturing Company, spoke on "Production of Radioactive Isotopes," and Dr. Byron E. Hall of the Mayo Clinic, Rochester, Minnesota, gave a talk entitled, "Radioactive Phosphorus Therapy."

AND ABOUT THE THIRD DISTRICT:

"With a marked concentration of physicians in the Third Councilor District, the *Journal* is assembling all news items pertaining to activities of physicians in Dane, Rock, Green, Columbia, Sauk, Marquette and Adams Counties and presents them together. The *Journal* urges county secretaries to send personal items of interest. Such notices should reach our office by or before the fifteenth of each month before publication."

—Editor's Note

SOCIETY PROCEEDINGS

Dane

The May 14 meeting of the Dane County Medical Society was held at the Madison Club in Madison. The program consisted of a talk, illustrated with colored slides, by *Dr. Arthur A. Holbrook* of Milwaukee. His subject was, "Skin Diseases in the Southwest Pacific Area as Seen by an Internist."

The program followed a meeting of the Board of Trustees.

Green

Dr. Nels A. Hill of Madison spoke on "Geriatrics" before the April 30 dinner meeting of the Green County Medical Society, held at the Eugene Hotel, Monroe. General discussion followed the talk, and a unanimous vote was given to administer Pertussis vaccination to school children, as a county program.

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Councilor District News

Dr. Frederick Mohs, professor of chemo-surgery at the University of Wisconsin, spoke on "Cancer" at the May 12 meeting of the East Side Woman's Club of Madison. Slides illustrated the speech.

—△—

Dr. Chester Kurtz, heart specialist at Wisconsin General Hospital, Madison, and in charge of a rest home near Madison for children with rheumatic fever, spoke on "Rheumatic Fever," May 18, when the Poynette Woman's Club was hostess to the Columbia County Federation of Women's Clubs.

—△—

Dr. William S. Middleton, dean of the University of Wisconsin Medical School, and a consultant in medicine in the European Theater in wartime, reported on Army medical practices May 14, before the American College of Physicians at the opening of its twenty-seventh meeting, held in Philadelphia.

Describing observations made among German prisoners of war, Doctor Middleton said, "only the Luftwaffe and certain paratroop elements received prophylactic vaccination. The remaining unprotected German prisoners afforded a horrible control (contrast) in their high morbidity and mortality from tetanus."

He said that all American troops were protected from tetanus by being vaccinated with tetanus toxoid, and men who were injured received a "booster" dose. Only one isolated case of lockjaw occurred among all Americans in the European Theater. That man died.

The doctor related that in November, 1943, influenza made its appearance "in an explosive epidemic" among our troops. But, fortunately, it was free from complications and mortality.

—△—

In Madison, two hundred doctors registered attendance at the two-day postgraduate clinic held at the Jackson Clinic, May 16 and 17. The meetings were devoted to subjects based on work which may be used in everyday clinical practice, and were designed to serve as a refresher course for doctors returning from service.

Dr. Karl Meyer, associate professor of surgery at the University of Illinois and medical superintendent of Cook County Hospital in Chicago, gave the chief address at the May 16 dinner meeting at the Loraine Hotel.

Before the June 21 afternoon session of the American Association for the Study of Goiter convention, *Dr. Arnold S. Jackson* of Madison, will give a speech entitled, "The End Results of Thyroidectomy in Exopthalmic Goiter, Twenty Years' Postoperative." The association will hold its meetings at the Drake Hotel in Chicago, June 20, 21, and 23.

SOCIETY RECORDS

New Members

O. R. Kelley, St. Mary's Hospital, Wausau.

A. C. Edwards, Department of Health, Racine.

J. S. Allen, Norwalk.

F. W. Reibold, 1574 Ogden Avenue, Superior.

A. T. Leininger, Green Lake.

J. C. Cook, 828 College Avenue, Racine.

R. B. Edelstein, 535 Main Street, Racine.

W. E. Luedtke, 2050 Charles Street, Racine.

J. R. Nickelsen, Box 190, Racine.

Changes in Address

H. E. Fillbach, Burbank, California, to Cuba City.

C. G. Steinke, Goodman, to 517 Stephenson Avenue, Iron Mountain, Michigan.

James Christiansen, Waukesha, to 1612 Jones Street, Sioux City, Iowa.

Lewis Danziger, Milwaukee, to 1215 Dewey Avenue, Wauwatosa 13.

R. D. Bergen, San Diego, California, to 6353 N. Berkeley Boulevard, Milwaukee 11.

G. E. Wesche, Hayward, to 311½ Fourteenth Avenue South, Nampa, Idaho.

E. W. Vetter, New York, New York, to Mercy Hospital, Canton 3, Ohio.

A. R. Remley, Waupun, to Union Grove.

L. M. Cox, Chicago, Illinois, to Central State Hospital, Waupun.

H. J. Jeronimus, Osceola, to 4702 Tioga Street, Duluth, Minnesota.

L. L. Fifrick, Plymouth, to 8721 West North Avenue, Wauwatosa 13.

E. R. Otterholt, Janesville, to The California Hospital, 1414 South Hope Street, Los Angeles, Cal.

S. C. Peterson, Luck, to 2305 Twenty-eighth Avenue South, Minneapolis, Minnesota.

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News Items and Personals

Honoring *Dr. Eben J. Carey*, who has been dean of the Marquette University School of Medicine for twenty-five years, a testimonial dinner was given by the Medical Society of Milwaukee County May 2, at the Hotel Schroeder in Milwaukee.

—△—

A double job in public health work was recently bestowed on the Pfeifers, father and son. While *Dr. R. H. Pfeifer*, recently discharged from the Army, was being appointed Clintonville city health officer for a two year term, his father, *Dr. F. J. Pfeifer*, received the same term as city health officer of New London.

—△—

Upper Wisconsin's venerable physician, *Dr. J. M. Dodd, Sr.*, 79, former mayor of Ashland, left April 30 for Neknak, Alaska, where he will spend the summer as superintendent of the hospital of the Red Salmon Canning Company. Flying up from Seattle, Doctor Dodd planned to arrive in a day, a short trip compared to the boat voyage of eight days that he has taken the last three summers.

—△—

A World War I veteran and a member of the state guard unit at Neenah since its inception, *Dr. T. D. Smith*, Neenah physician, was recently appointed senior medical officer of the Wisconsin State Guard. Doctor Smith was serving as a lieutenant colonel for the second regiment of the 127th Infantry until this appointment, made by General Scott A. Carey, brigadier general of the State Guard.

—△—

Dr. F. G. Jensen of Menasha, speaking before members of the Menasha Rotary Club April 24, described the conditions and adventures he encountered while serving with the Navy Medical Corps at Pago Pago, the Russell Islands, Guadalcanal, and New Caledonia. Doctor Jensen reported that hospital accommodations went from one extreme to the other; in the Russell Islands the hospitals were without beds and families of the patients had to provide the food.

—△—

Dr. Samuel Plahner of Milwaukee, psychiatrist and consultant psychologist, addressed an audience April 23, at Jefferson Hall in Jefferson. His speech, given at a lecture sponsored by the Free Thought Society, was entitled, "Juvenile Delinquency."

(Continued on page 630)

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(Continued from page 628)

A fiftieth anniversary dinner was held in Milwaukee, May 26, for Dr. Paul Hankwitz, former member of the State Medical Society, and his family at the Hankwitz home. Three generations of the family have served Milwaukee's south side as physicians. Dr. Paul and his father, the late Dr. Carl E. Hankwitz, practiced as partners from 1901 until the latter's retirement in 1904. In June, 1934, *Dr. Arthur W. Hankwitz* joined his father in practice. Dr. Paul Hankwitz retired in 1941, after having delivered 4,000 babies for south side residents.

—△—

Dr. Lyman A. Copps of the Marshfield Clinic, spoke before a public meeting May 2, at the Morgan School Auditorium, Appleton, in connection with the observance of National Health Week. In his talk, sponsored by the Outagamie Medical Society, its auxiliary, and other, Doctor Copps discussed federally controlled medical plans and state plans for group medicine.

—△—

Three Neenah–Menasha physicians presented the program at the pathological conference of the medical staff of Theda Clark Memorial Hospital, May 10. *Dr. G. N. Pratt, Jr., Dr. A. P. Graham,* and Dr. E. R. Strausser were the speakers.

—△—

At 89, *Dr. H. F. Ohswaldt* of Oconto Falls, is starting his sixty-seventh year of practice. The doctor, who has brought about 75 per cent of Oconto Falls residents into the world, is still in good health and lives by a simple reminder to "keep mind and muscle in shape by exercise."

Doctor Ohswaldt is the only surviving member of the 1879 graduating class of Bellevue Hospital Medical College, New York City. One of his classmates at college was George Goethals, famous for his battle against malaria in the Panama Canal.

Doctor Ohswaldt began his practice in Waverly, New York, and then transferred to Green Bay. He went to Oconto Falls from Stiles, Wisconsin, where he served railroad men, loggers, and paper mill employees in addition to other members of the community.

—△—

Dr. Clifford H. Kalb of Milwaukee, a Fellow in the department of allergy at the University of Illinois, recently presented a paper entitled, "The Importance of Atmospheric Fungi in Allergy," before the Chicago Society of Allergy.

—△—

Dr. Warner S. Bump of Rhinelander, who was recently appointed a director of the American Cancer Society, in the early part of May made a trip to New York City and attended a meeting of the board of directors of the society. Doctor Bump also is chairman of the Wisconsin cancer committee and a member of the board of directors of Region Four of the Field Army, which comprises the six states of Michigan, Minnesota, Wisconsin, Iowa, Illinois, and Indiana.

DEATHS

Dr. Cornelius H. Cremer, 82, a Monroe County physician for many years, died at his home, Thursday, April 25.

Doctor Cremer graduated from Rush Medical College in 1889 and attended the Kentucky School of Medicine in Louisville before starting his practice in Cashton.

In 1939, he was honored at a ceremony celebrating his fiftieth year of medical practice. He was a member of the Monroe County Medical Society, the State Medical Society, and a past-president of the State Board of Medical Examiners.

A member of the Cashton school board intermittently for twenty-six years, the doctor was helpful in organizing the town high school.

He is survived by two daughters and a son.

Dr. Frederick P. Knauf, 69, physician and surgeon at Kiel for forty-three years, died suddenly at his home on Wednesday, May 15.

Born in Sheboygan, Doctor Knauf graduated from the University of Illinois College of Medicine, Chicago, in 1900 and began practice in New Holstein in 1903. During the same year he moved to Kiel and was associated with the late Dr. S. R. Sleyster until 1905.

Doctor Knauf was a member of the Calumet County Medical Society and the State Medical Society. He was also a fellow in the American Medical Association.

Surviving are his wife, two daughters, and a son.

Dr. Walter F. O'Connor of Ladysmith, a pioneer surgeon of Rusk County, died at a local hospital Thursday, April 25, after an illness of several months. He was 71 years old.

After graduation from the Wayne University College of Medicine, Detroit, in 1897, Doctor O'Connor served a nine months' internship at St. Mary's Hospital in Detroit. He practiced in Cooperstown before settling in Tony, a logging village in what is now Rusk County. In 1904 he moved to Ladysmith, where he joined the staff of St. Mary's Hospital.

Doctor O'Connor was president of the Rusk County Medical Society, a member of the State Medical Society, and a Fellow in the American Medical Association.

Survivors include his wife and three children.

Dr. Chester H. Perkins, well-known Kenosha physician, died at a local hospital Friday, May 3, after an illness of a few weeks. He was 49 years old.

Following his attendance at Norman University, Norman, Oklahoma, and graduation in 1918 from the University of Illinois College of Medicine, Chicago, he was the doctor for the Illinois Steel Corporation at Joliet, Illinois and Gary, Indiana.

He served his internship at Cook County Hospital in Chicago during a part of World War I and received an honorable discharge from the service. Later he practiced medicine in Pittsburg, Kansas,

(Continued on page 636)

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MRS. CHARLES FIDLER

Mrs. Fidler has served as a past treasurer, chairman of the circulation of the Bulletin, co-chairman and delegate to the National Convention, and National Corresponding Secretary. Active in the Milwaukee County Auxiliary, she has been treasurer and a program and Bulletin chairman.

For the past four years she has been on the Red Cross Volunteer Nurse's Aide Corps Committee.

MRS. F. W. POPE

Mrs. Pope is a past treasurer and a past president of the Woman's Auxiliary, and served two years as president of the Racine County Auxiliary.

She is a member of the Woman's Club and Garden Club of Racine.

The nominating committee is elected by the Board of Directors at the post-convention meeting. This committee is composed of five members and five alternates. The chairman is appointed by the president from among the members of the committee. The duty of this committee is to prepare a slate of proposed candidates for such offices as will be vacant. The committee is to obtain in writing the consent of all nominees for office and, through the corresponding secretary, shall include the slate with the call to the annual meeting. Each county auxiliary shall be entitled to send to the general meeting its president and her alternate and one delegate and her alternate. In addition each auxiliary shall be entitled to one additional delegate and her alternate for each fifty full-paid members, or major fraction thereof, over and above the first fifty members.

May I urge you to forward the names of members who are planning to attend the National convention in San Francisco, July 1–6. The Delegates will be selected from this list.

Members of the finance committee, Mrs. Leif Lokvam, immediate past-president; Mrs. N. A. Hill, state treasurer; and I, as chairman, hope to carry out our duties as prescribed.

In making up the 1946–47 budget we shall try to plan wisely. This budget is based on estimated income from dues (50 cents each) and $100 from the State Medical Society. With this amount items such as national dues and reimbursement for expenses of state officers and committee chairmen are paid. There is also a miscellaneous fund created.

We requested that all bills be sent in before June 1 of this year and those who responded were taken care of promptly. These amounts are passed upon by the chairman of the finance committee, the president, and the state treasurer.

As our budget is limited all of the suggestions that are made cannot be carried out, and if we stay well within our allowances and perhaps have something left over for emergencies we shall be happy to have served you.

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Auxiliary Proceedings

Brown—Kewaunee—Door

Members and guests of the Woman's Auxiliary met on April 24 at the home of Mrs. Glen F. Denys, Green Bay, to hear Dr. P. R. Minahan, president of the State Medical Society, discuss federal bills, now before Congress, relating to compulsory political systems of medicine. Doctor Minahan pointed out that the results of similar systems in Europe had not been satisfactory and warned that if such legislation in this country is passed, it will not bring free medical service since the cost would be withheld from the earners' paychecks. He said it would produce a payrollers' paradise where the major portion of the medical fund would be absorbed by the politicians operating the system. "The sick person would have no free choice of doctor, hospital, or medicine, regardless of the extravagant claims of proponents of the bills," according to Doctor Minahan. Guests included women who are prominent in other organizations.

Dane

The regular meeting of the Dane County Auxiliary was held at the home of Mrs. Ralph E. Campbell, Madison, on May 13 for dessert and bridge. Assisting hostesses were Mmes. Stuart McCormick, John Waddell, Frank K. Dean, William A. Mowry, and Frederick Mohs.

Douglas

The Auxiliary of the Douglas County Medical Society met May 1 at the Androy Hotel, Superior, for dinner. Mr. O. H. Flint, representative of the Eli Lilly Pharmaceutical Company, was guest speaker and gave a talk on the history of drugs.

Fond du Lac

The members of the Fond du Lac Auxiliary spent the afternoon of April 25 at the home of Mrs. H. C. Werner, Fond du Lac, making cancer dressings. Later, dinner was served at the Elks Club, after which there was a short business meeting with Mrs. Leo Hoffmann presiding. Plans were made for a joint dinner of the Medical Society and the Auxiliary to be held in May at Green Lake. Mrs. H. R. Sharpe was appointed chairman of the nominating committee. Mmes. A. M. Hutter, H. C. Werner, E. V. Smith, Jr., and J. S. Wier were named hostesses for a tea to be given on May 16. Funds for the cancer control were presented to Mrs. J. P. Connell, county captain. The remainder of the evening was spent making cancer dressings.

La Crosse

The La Crosse County Auxiliary met at the home of Mrs. Alf H. Gundersen, La Crosse, on April 17. Hostesses were Mmes. John C. Harman, Edward S. Carlsson, George D. Reay, and Paul Anderson. Guests included members of the board of directors of the La Crosse Home for Children and St. Michael's Orphanage. Mrs. Joseph Richter, Chaseburg, reported on "Black Market Babies." Mrs. Richter said that whereas the Wisconsin adoption laws are good, there is still room for improvement, for even in this state there have been instances where babies have been bought and sold. The solution to the problem, she pointed out, lies in educating the public not to ostracize an unwed mother, to give her adequate information about where her baby can best be placed for adoption, and to stress the importance to prospective adoptive parents of obtaining their children only through legal channels.

Mrs. Gunnar Gundersen conducted the second half of the program devoted to a discussion of the National Health bill now being considered by Congress. She explained that this bill would provide four billion dollars annually for personal health services but that in reality only about half of that amount would actually be used for that purpose. Mrs. Oscar Kanner gave a resumé of her experience with state medicine in Austria, where only a very small percentage of the money allocated for medical service was so used, the balance being absorbed by the political organization. The Auxiliary voted to telegraph Congressman William H. Stevenson asking him to vote against the bill, and donated three books to the La Crosse Public Library so that they can be available for informing the public on the various aspects of the bill. The books are: "Health Education of the Public" by W. W. Bauer and Thomas G. Hull; "The Business Side of Medical Practice" by Theodore Wiprud, and the "True Physician" by Wingate Johnson.

Manitowoc

The Auxiliary members met at the Hotel Manitowoc April 17 with Mmes. J. W. Steckbauer and W. A. Rauch as hostesses. Mrs. B. A. Crane, Two Rivers, gave a most interesting and entertaining talk about Mexico. A display of Mexican arts and crafts was used to illustrate her description of the native customs, handcrafts, art, and music.

Outagamie

Members of the Winnebago County Auxiliary were guests of the Outagamie County Auxiliary at a meeting held on April 25 at the Guest House, Appleton, at which Mrs. Arthur M. McCarey, Green Bay, state president, was guest of honor. Arrangements for the luncheon were made by Mmes. Milo Swanton, and Don W. Curtin, Kimberly. Members of the reception committee were: Mmes. G. W. Carlson, E. N. Krueger, and E. F. McGrath.

Following the luncheon Mrs. J. W. Laird, state public relations chairman, introduced Mrs. McCarey who discussed pending legislation relating to political medicine. "It is essential that the auxiliary membership keep itself well informed as to the

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attempts made to change the status of the practice of medicine," she stated. She suggested the formation of study groups, radio broadcasts, and public meetings with speakers, as some of the projects by which the Auxiliary could inform the public on the issues of this legislation. Among the guests who attended the meeting were Mmes. F. L. Crikelair and Glen F. Denys, both of Green Bay, president and president-elect of the Brown–Kewaunee–Door Auxiliary, and Mmes. Byron J. Hughes and J. B. Kilkenny, both of Oshkosh, president and president-elect of the Winnebago County Auxiliary.

Mrs. F. J. Huberty, president, announced that a program, to be held in Appleton on May 2, in celebration of National Health Week, had been arranged. Dr. Lyman A. Copps, Marshfield, would speak on "Federally Controlled Compulsory Health Insurance as Opposed to Privately Controlled Medical Insurance."

DEATHS

(Continued from page 630)

spent a short time in Harvard, Illinois, and then moved to Chicago, where he worked for the chief surgeon of the C. B. & I. Railroad.

Moving to Kenosha in 1925, the doctor practiced there until his retirement six months ago.

Doctor Perkins was a member of the Proctological Society, the Kenosha County Medical Society, the State Medical Society, and the American Medical Association.

The doctor is survived by his wife.

Dr. William F. Ragan, 59, a heart specialist at Sacred Heart Sanitarium, Milwaukee, for twenty-nine years, died at his home in Whitefish Bay, Monday, May 6.

The doctor, a 1908 graduate of Marquette University School of Medicine, formerly practiced in Shawano. He was a member of the Medical Society of Milwaukee County, the State Medical Society, and a Fellow in the American Medical Association. Doctor Ragan was also a member of the Wisconsin Heart Club and the Academy of Medicine.

Surviving are his wife and one daughter.

Dr. Willis G. Murphy, 29, of Goodman, died Wednesday, May 13, in an Iron Mountain, Michigan hospital from injuries received in an automobile accident.

Dr. Murphy graduated from the University of Wisconsin Medical School in 1941 and served four years in the Army Medical Corps. He had recently started a general practice in Goodman.

The doctor is survived by his wife and one daughter.

THE JOURNAL BOOKSHELF

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, S. M. I. Building, Madison, Wis.

Bedside Clinics of Francis D. Murphy, M. D., F. A. C. P. By Francis D. Murphy, M. D., F. A. C. P., Professor and Head of the Department of Medicine of the Marquette University Medical School and Clinical Director of the Milwaukee County General Hospital and Emergency Unit. Volume I. Cloth. Price $3.00. Pp. 185 with charts and tables. Milwaukee: Marquette University Press, 1945.

"The object of the Bedside Clinics is to present to the student and to the physician a report of an exemplary case and a brief discussion" of the case. Medical advances in this way are brought to the attention of the reader before they appear in text book form and, in addition, the author is enabled to carry his teachings far beyond the classroom.

These clinics are worthy of the attention of the reader. They are all short and cover a wide variety of medical conditions such as are encountered in daily practice. Only material of practical clinical value is included. Cardiac clinics head the list with seven. In addition to these there are five each on common abdominal conditions and metabolic disturbances with other clinics on the blood, nervous system, lungs, kidneys, liver, and infections. Penicillin and renal damage from the sulfonamides are discussed.

A typical clinic follows the form of: history, physical findings, summarization, and treatment, followed by questions and answers supplemented by a list of references. It is possible by way of references to obtain quickly information from any part of any clinic regarding any subject. K. L. P.

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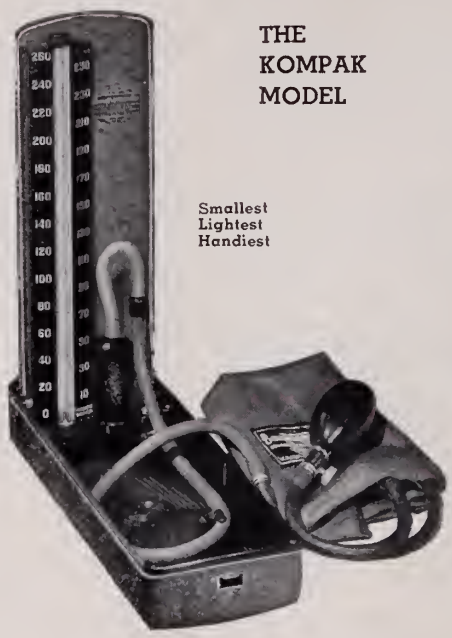

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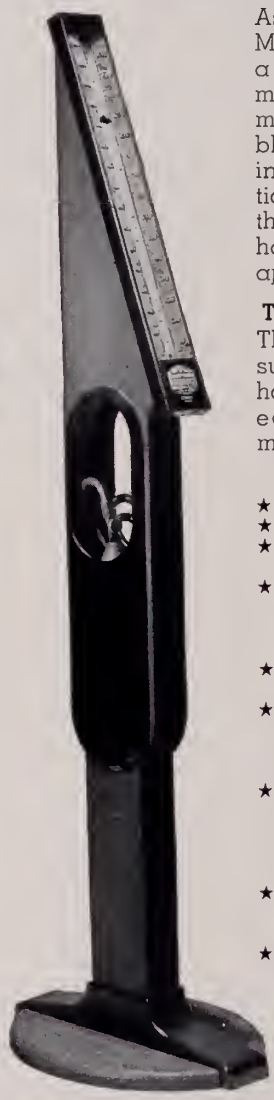

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—WALTER H. JAESCHKE, M. D., *University of Wisconsin.*

(Continued from page 603)

If we are to keep the legislators up to date we must maintain regular and publicly-known sources of information. The usual information offices in our state capitals must be kept up and we must, on a national basis, maintain a similar service in Washington, D. C., for the benefit of our Congressmen and Senators.

Our state and national offices must be effective, must be manned by capable and experienced men, and must participate in pending, proposed, or actual legislative measures. Unless we maintain a constant vigil we may find ourselves in the position we had to accept a few years ago, when the EMIC program broke over our heads without forewarning. That one experience should be enough to keep us on our toes from here on.

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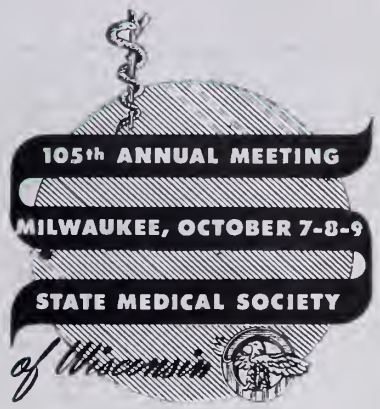

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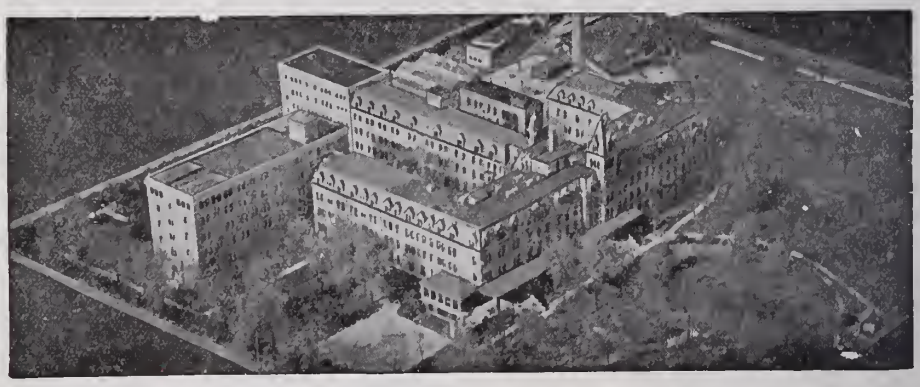

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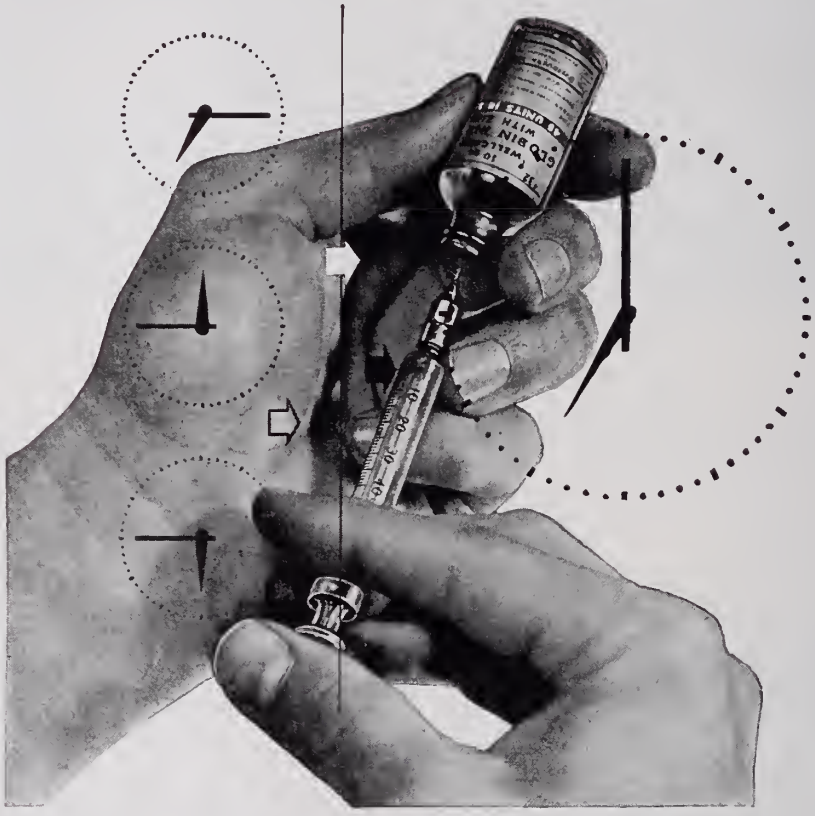

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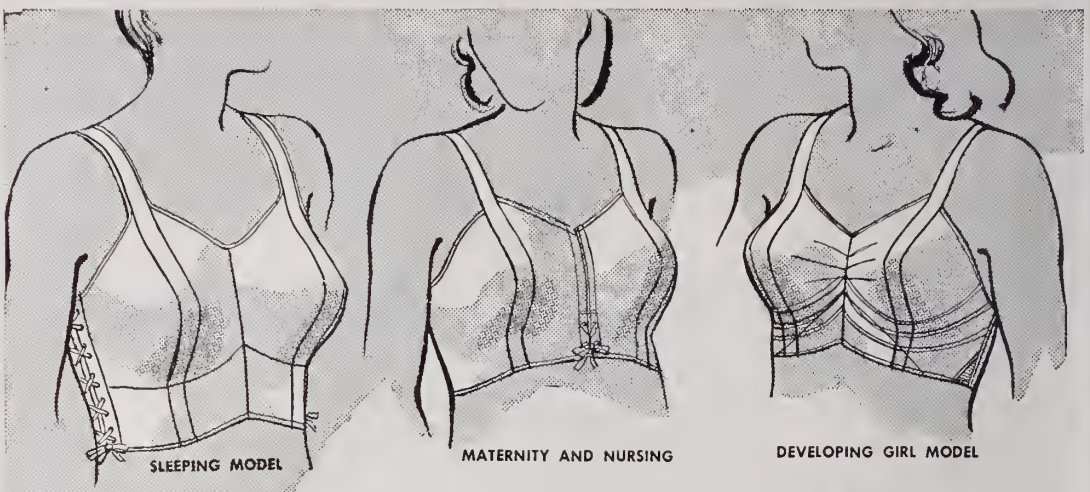

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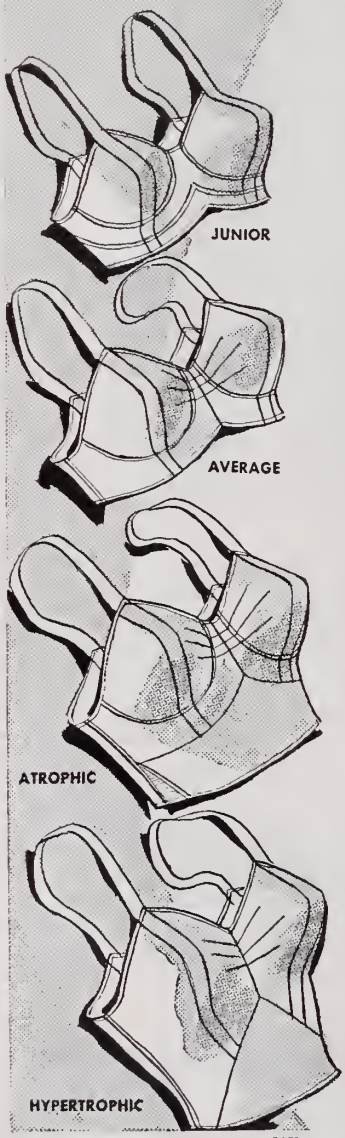

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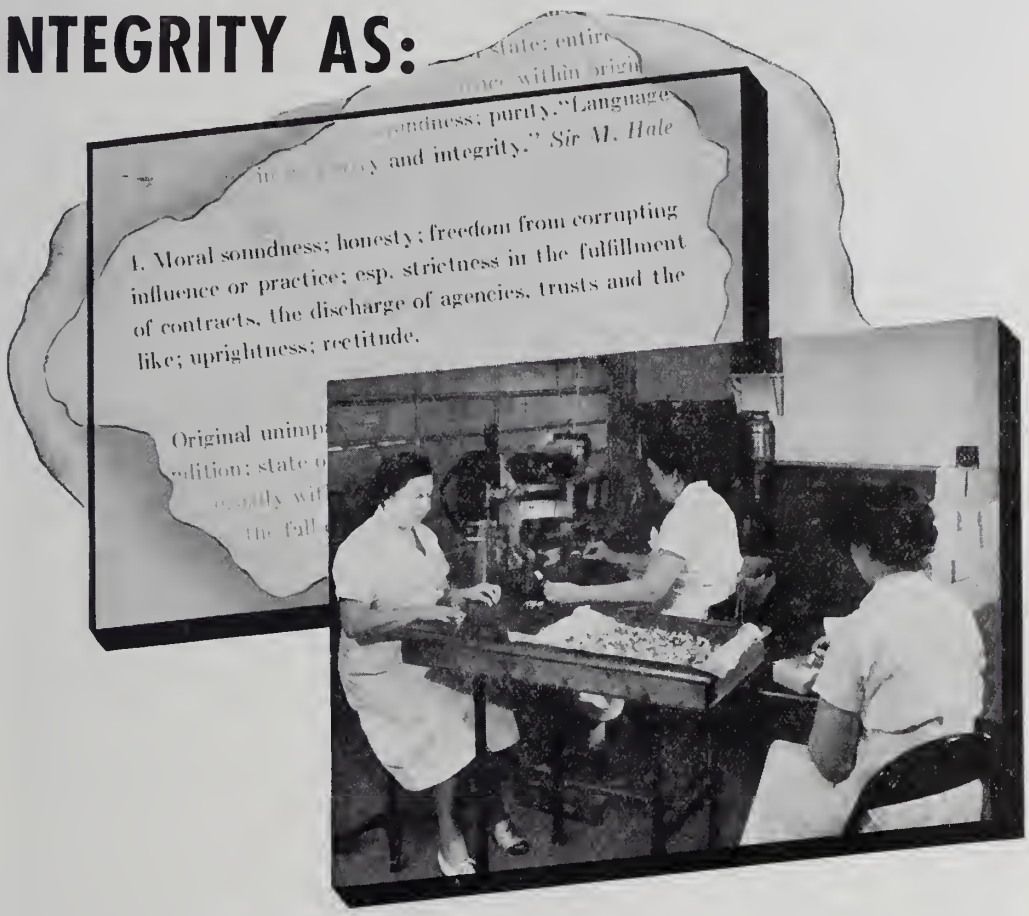

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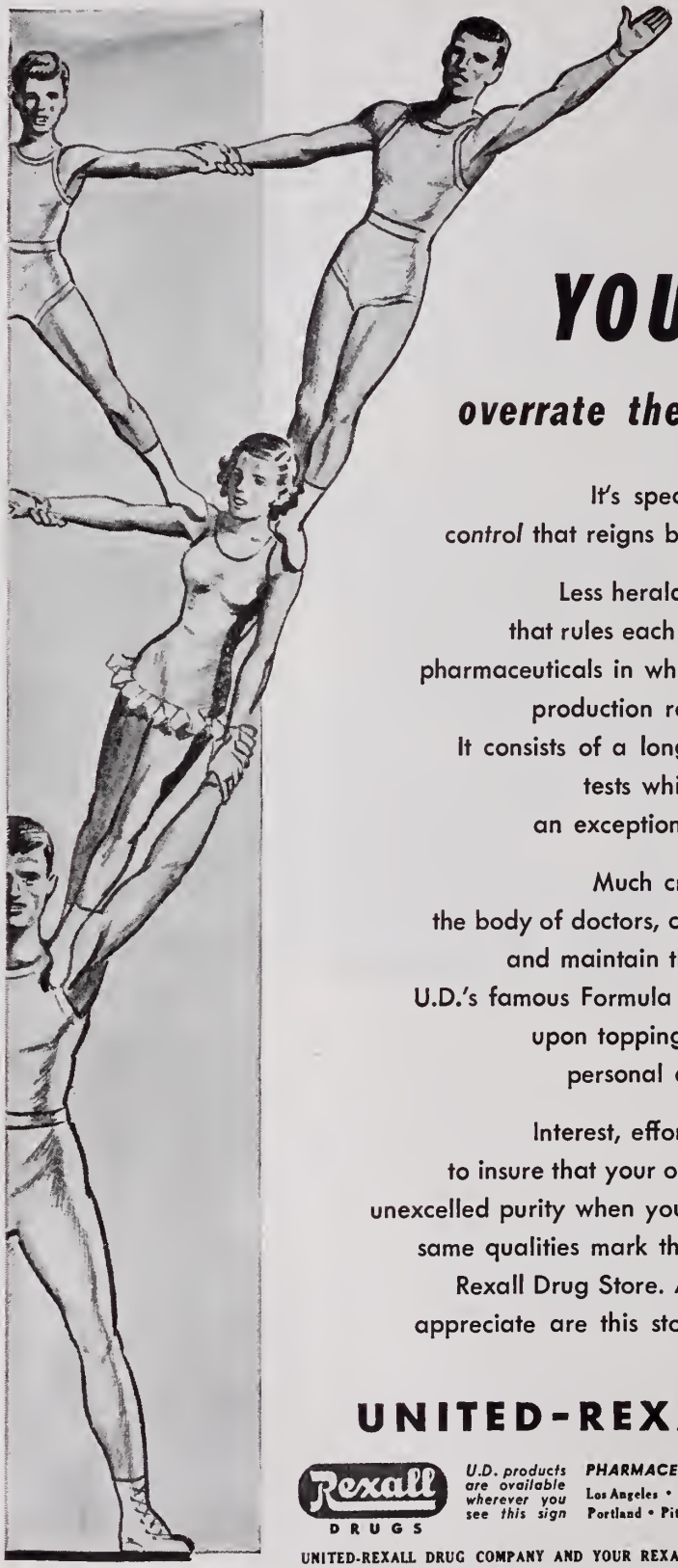

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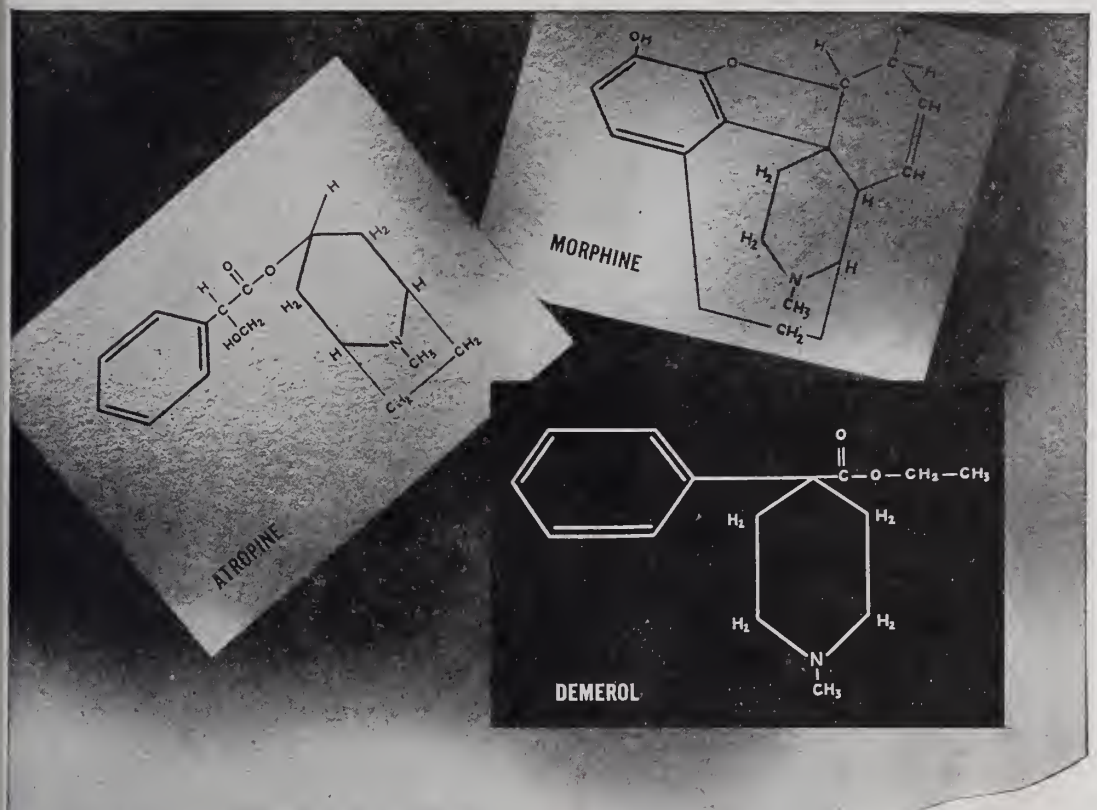

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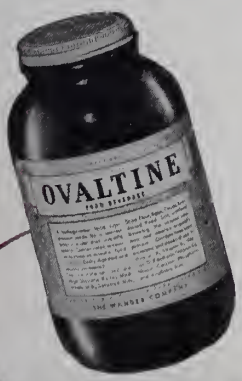

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*Harding, F. E.: Am. J. Obst. & Gynec., 51:660 (May) 1946

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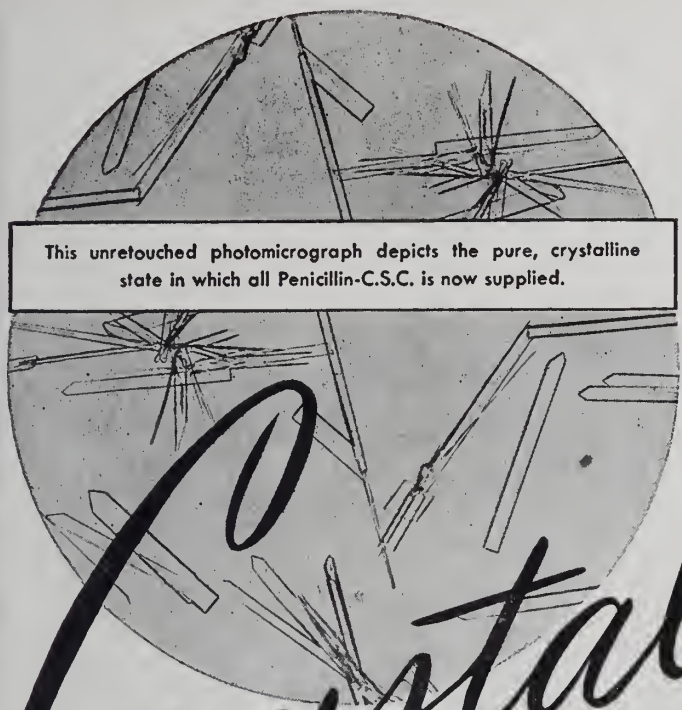

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Crystalline Penicillin Sodium-C.S.C. is available in serum-type vials containing 100,000, 200,000, or 500,000 units.

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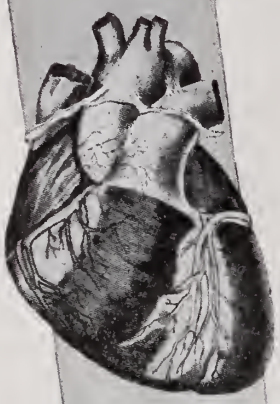

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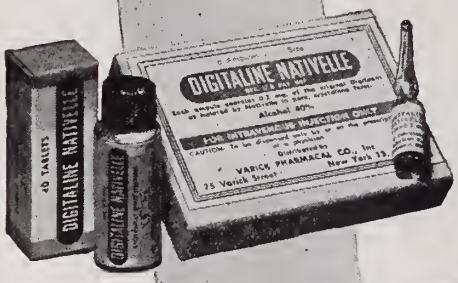
[1] Gold, H.; Cattell, M.; Modell, W.; Kwit, N. T.; Kramer, M. L., and Zahm, W.: J. Pharmacol. & Exper. Therap. 82:187 (Oct.) 1944.
[2] Gold, H.: Connecticut M. J. 9:193 (Mar.) 1945.
[3] Levine, S. A.: Clinical Heart Disease, ed. 3, Philadelphia, Pa., W. B. Saunders Company, 1945, p. 273.

Physicians are invited to send for samples, literature, and bibliography.



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THE WISCONSIN MEDICAL JOURNAL

VOLUME 45, NO. 7 Copyright, 1946, by The State Medical Society of Wisconsin JULY, 1946

Thiouracil*

By ARNOLD S. JACKSON, M. D., F. A. C. S.
Madison

A. S. JACKSON

A graduate of Columbia University College of Physicians and Surgeons, New York, in 1919, Doctor Jackson completed a Fellowship in Surgery at Mayo Clinic, and then secured a Master of Surgery degree from the University of Minnesota. The doctor is director of the Nishan Foundation for the Study of Goiter, and for the past ten years has served as chairman of the Committee for the Prevention of Goiter, of the State Medical Society.

IN JANUARY, announcement was made by drug manufacturers of the release of thiouracil to the medical profession. This drug has been under clinical investigation since 1943 by a group of institutions and individuals who have been studying its effect on the treatment of goiter. The drug was not released sooner because it may cause severe and even fatal toxic reactions.

Like amidopyrine, thiouracil may cause agranulocytosis, and, despite its careful restriction, 21 deaths are already known to have resulted from its use. A recent report of the Council on Pharmacy and Chemistry of the American Medical Association listed 168 cases of agranulocytopenia as having occurred in 5,745 cases.[1] Recent studies suggest that large doses of penicillin, up to 500,000 units a day, are the most effective method of treating this serious complication.

Before the use of amidopyrine was restricted, over 1,300 deaths from agranulocytosis occurred in the United States alone from persons taking various sedatives. The drug was combined with other preparations and sold under various trade names, so frequently the physician did not realize that he was prescribing amidopyrine.

Just as with amidopyrine, thiouracil may be taken for weeks and months, and then for no apparent reason an allergic reaction develops, and agranulocytosis occurs. Thiouracil, however, if used with care and discrimination, can be the means of helping to save many persons afflicted with toxic goiter. It has proved beneficial in approximately 84 per cent of 2,000 treated cases. Yet it is alarming to see the reported amounts of the drug that have been given to some patients. Certainly no physician should dispense any larger dose of a potentially dangerous drug to his patients than he would to members of his own family.

We have been studying the effect of thiouracil in hyperthyroidism for the past three years at the Frieda Meyers Nishan Foundation and have made the following deductions: Thiouracil will not supplant thyroidectomy in the treatment of multiple toxic adenomata, but in preoperative preparation it is more effective than Lugol's solution. Iodine benefits not over 32 per cent of these cases, but nearly 80 per cent of patients having this type of goiter improve with thiouracil. In advanced cases of this type, where considerable damage to the cardiovascular system has occurred and where the surgical risk is high, this new drug has proved of greatest benefit. Many of these patients can be so improved that a one-stage rather than a two-stage thyroidectomy may be performed.

* The Frieda Meyers Nishan Foundation for the Study of Goiter of the Jackson Clinic.

Fig. 1.—This 12 year old child did not respond favorably to thiouracil, and after several months' trial, thyroidectomy was performed.

In cases of so-called "iodine-fast" exophthalmic goiter, a term suggested for those persons kept on iodine so long that its beneficial effect is destroyed, thiouracil may be helpful. By gradually reducing the iodine and giving thiouracil, the patient may be given a rest from the former without losing ground. Then, after a free interval, the process may be reversed, and as soon as the patient's condition is under control by iodine, operation may be performed.

Although pregnancy complicated by exophthalmic goiter is of uncommon occurrence, when it does happen, there may be a serious question as to what is the best thing to do. If the disease develops early in pregnancy, usually thyroidectomy may be performed safely after ten to fourteen days of preoperative preparation. In my experience, this procedure has resulted in no disturbance in the pregnancy. When, however, late pregnancy is complicated by exophthalmic goiter, the problem is more serious. Attempting to carry the patient to term on iodine may result in an "iodine-fast" condition. Preferably, thiouracil may be given and the patient carried along until one or two months past term, and, then, after iodine preparation, safely operated upon.

In all bad risk types of hyperthyroidism that may be complicated by diabetes, hypertension, and marked cardiac damage, thiouracil is a useful adjunct to surgery. In recurrent exophthalmic goiter, the drug gives promise of effecting a cure without further surgery. I have 3 cases of this type that received the drug for a long period and who are now symptom-free six months or more after its withdrawal. In the aged and in children where the risk of surgery may be increased, the drug is beneficial. I have one patient who sustained a bilateral adductor paralysis of the recurrent laryngeal nerves following thyroidectomy elsewhere and who then developed a recurrence of an exophthalmic goiter. In this condition the patient was considered an unfavorable surgical risk, and for the past three years the disease has been controlled by thiouracil.

The question arises: Will thiouracil prove effective in curing exophthalmic goiter? Sufficient time has not elapsed, nor has a large enough series of cases been studied to warrant definite conclusions on this point. Our

Fig. 2.—A patient with "iodine-fast" exophthalmic goiter prepared with thiouracil on whom a primary thydroidectomy was performed.

studies, based only on a series of 50 patients, do not yet indicate that the drug will effect a cure in a large percentage of cases. It is often difficult, if not impossible, for a pa-

tient to travel any considerable distance to have a check of the white blood count every two weeks, month after month. Moreover, unless it is possible to examine such a patient frequently, one may hesitate to subject him to the possibility of developing agranulocytosis when thyroidectomy may be performed at a risk of 1 per cent or less, and the patient's health speedily restored. It is true that in approximately 5 per cent of the cases a persistence or recurrence of hyperthyroidism may occur following thyroidectomy. Further time and study will be required to determine whether or not thiouracil may replace thyroidectomy in any considerable number of cases of exophthalmic goiter.

It is apparent that this drug will inject new problems for those who are interested in the treatment of toxic goiter. Diagnosis of exophthalmic goiter may at times prove baffling because, as Osler said of syphilis, its symptoms are so varied that it may simulate many diseases. The introduction of Lugol's solution further complicated the problem of diagnosis by frequently masking for the time being the signs and symptoms of the disease. Now thiouracil will add further difficulties to the question of diagnosis.

Thiouracil complicates the surgeon's problems by increasing the vascularity of the gland and the tendency to bleeding at operation. This may be lessened by stopping the drug a few days before surgery and giving iodine for at least a week in advance of thyroidectomy.

The matter of dosage has been adequately discussed in the literature, and I only wish to reiterate that no physician should prescribe a large dose of the drug without fully appreciating the risk to which he is subjecting his patient. We perhaps have been unduly cautious and have seldom used more than .4 Gm. a day, although the literature contains reports of twice this amount or more being used. It should be given in doses of 0.1 Gm. three or four times a day and should be reduced as soon as indicated by the patient's improvement. Many patients can be maintained on 0.1 Gm. to 0.2 Gm. a day.

In our experience with the drug, we have been fortunate, having had no serious complications in our small series of cases. In two instances a rash developed, necessitating stopping the drug. All our patients have been instructed as to the possible complications, such as sore throat, fever, rash, arthritic pains, nausea, diarrhea, vomiting, parotitis, purpura, jaundice, edema, dizziness, and headache. They have all been told to stop the drug at once should any of these symptoms of drug intolerance develop.

Thiouracil has proved of valuable assistance in the treatment of hyperthyroidism already, but it is to be hoped that a less toxic drug will be discovered to replace it.

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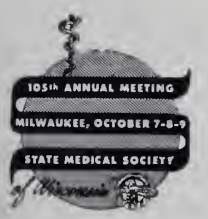
HAVE YOU RESERVED YOUR ROOM?



Milwaukee hotels report increasing difficulty to reserve rooms on "last minute" calls. If you have not already done so, make your reservations for accommodations to cover the 1946 Annual Meeting.

The House of Delegates convenes on Sunday, October 6, so all delegates, Councilors, and others who desire to attend the opening session of the House should reserve their rooms starting on Sunday.

Scientific sessions will be held on Monday, Tuesday, and Wednesday, October 7–8–9. The House of Delegates and sessions involving meal service will be held at the Hotel Schroeder.

Roentgen Therapy of Pituitary Adenomas*

By JOSEPH A. MUFSON, M. D. and SAMUEL S. BLANKSTEIN, M. D.
Milwaukee

J. A. MUFSON

A graduate of the Johns Hopkins University School of Medicine in Baltimore with the class of 1937, Doctor Mufson has been practicing neurological surgery in Milwaukee since 1944. He is attending neurosurgeon at Mt. Sinai Hospital, Milwaukee, and associate attending neurosurgeon of the Milwaukee County General Hospital.

S. S. BLANKSTEIN

Doctor Blankstein, attending ophthalmologist at Mt. Sinai Hospital, Milwaukee, graduated from Rush Medical College, Chicago, in 1934. The doctor holds membership in the American Academy of Ophthalmology and Oto-Laryngology, and the American Board of Ophthalmology.

WITH our increasing knowledge of the application of roentgen therapy to brain tumors gained during the past few decades, the non-surgical treatment of pituitary adenomas has assumed a new importance. There is perhaps no other tumor within the cranial cavity which shows such a striking and prolonged benefit from the effects of the roentgen rays. This radiosensitivity of pituitary adenomas has therefore become a subject of much discussion among neurosurgeons and radiotherapists. The aim of all this discussion and research has been to discover the optimum therapeutic procedure to be used in patients who show visual impairment due to compression of the optic chiasm by an enlarging adenoma. When confronted with such a problem the neurosurgeon is faced with several urgent questions: 1. Should the patient be subjected to immediate surgical decompression of the optic chiasm? 2. Should he first be given a trial of roentgen therapy? or 3. Should he receive the benefit of both surgery and roentgen therapy, and if so, in what order? A great deal of dispute has arisen in an attempt to answer these questions. There has been some tendency on the part of radiotherapists and neurologic surgeons to show preference for their own type of therapy. It is the purpose of this presentation to strengthen the argument for radiotherapy as the initial treatment of choice in pituitary adenomas and to certainly condemn routine surgical intervention in all cases.

Pathologic and Clinical Considerations

Before discussing the relative advantages of the two methods of treatment it might be pertinent to review briefly the pathology of pituitary adenomas and to consider the nature of the problem which confronts the physician chosen to treat a patient with such a lesion.

Adenomas of the pituitary gland may be divided into three main groups each corresponding to a particular type of cell which occurs normally in the anterior lobe of the pituitary gland. These cells are of two principal sorts, the chromophil and the chromophobe. The chromophil cells contain granules in their cytoplasm that have an affinity for dyes, and may be further subdivided into two types: 1. those with an affinity for acid dyes, especially eosin, and 2. those which have an affinity for basic dyes. The chromophobe or third type of cell, which is by far the most numerous, shows no affinity for these special dyes. The tumors which arise from these three types of cells are known therefore as the eosinophilic adenomas, the

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* From the Departments of Neurosurgery and Opthalmology Mount Sinai Hospital, Milwaukee.
Presented at the Meeting of the Milwaukee Neuropsychiatric Society October, 1944.

basophilic adenomas, and the chromophobe adenomas.

The eosinophilic adenomas are associated with acromegaly or gigantism. The endocrine symptoms and manifestations of this disorder are commonly regarded as an exaggeration of the normal function of the anterior lobe of the pituitary gland, that is to say as pathologic hyperpituitarism. The acromegalic therefore presents the picture of pathologic overgrowth of the skin, subcutaneous tissues, bones, and viscera. In addition there may be hyperglycemia and glycosuria and the metabolic rate is usually increased.

The basophilic adenomas are associated with the syndrome described by Cushing and characterized by: a peculiar adiposity of the face, neck, and body; a plethoric complexion of the skin with polycythemia; purplish atrophic skin striae on the abdomen, hips, and thighs; facial hirsutism in women; amenorrhea or impotence; vascular hypertension; glycosuria; and excessive elimination of calcium with osteoporosis. The constitutional disturbances occurring with this adenoma, as with the eosinophilic adenoma, are again due to the abnormal or hypersecretion of the cells of which the tumor is composed.

The chromophobe adenomas, on the other hand, presumably because of compression of the normal functioning pituitary gland, produce a constitutional state of hypopituitarism. The first symptom to appear is usually a depression of sexual function, which in women takes the form of scanty menstruation, progressing to complete amenorrhea, and in men to impotence. In striking contrast to the well known changes seen in acromegaly the skin becomes soft and pliable and there is often a loss of hair over the limbs and trunk, and over the face in men. Moderate obesity often develops and is associated with a lowered metabolic rate and increased sugar tolerance. Very often the symptoms of hypopituitarism are so mild as to escape notice until the local effects of the adenoma bring the patient to the physician.

Of the three types of adenoma the chromophobe is the most common, occurring three to four times as often as the eosinophilic adenoma. The basophilic adenoma is the least common. It is really a pathologic curiosity and of no surgical importance since it is very small and does not expand beyond the confines of the sella turcica.

In addition to the constitutional changes that occur in association with these adenomas of the pituitary gland there are the more important neighborhood symptoms produced by compression of vital structures in the para-sellar region. The most important structure in the vicinity of the pituitary gland is the optic chiasm. Pressure upon the optic chiasm by an underlying adenoma results in interference with the optic tracts. This leads to impairment of visual acuity followed by atrophy of the optic nerves, and if the pressure is continued indefinitely without interruption, complete blindness ensues. The visual fields show characteristic losses in the temporal aspect of each side, which may begin as a defect in the upper outer quadrant of each field, gradually extend to include the whole temporal half of each field, and eventually involve the nasal half as well. Occasionally there are symptoms due to pressure upon the neighboring hypothalamic portion of the brain producing disturbances in fat and water metabolism as well as disturbances in the sleep mechanism. Headache, which is a prominent symptom in these cases, develops as soon as the tumor grows large enough to stretch the dural capsule. The pain is dull and is usually felt behind the eyes or in both temples.

The problem in treating pituitary adenomas is twofold. First the effort is directed against the loss of vision resulting from compression of the optic nerves and chiasm. This is the all-important objective. Secondly, and of much less importance, is the attempt to restore function of the pituitary gland in the case of the chromophobe adenoma and to diminish the abnormal secretions of the adenoma in the case of the chromophil tumors. Since hormone therapy has proved ineffective to date the two major forms of therapy at present are surgical attack upon the adenoma and radiation applied to the

region of the tumor. Since both methods are capable of destroying adenomatous cells the issue resolves itself into which form of therapy is to be given preference in the initial treatment of these tumors.

Report of Cases

Case 1.—A. B., a 31 year old salesman, was first seen in July, 1941. Nine months previously he had begun to notice double vision and a "blind spot" in the left eye. The diplopia had become progressively worse. There were no other complaints. On direct questioning it was ascertained that three and one-half years previously there had been an episode of decreased libido and impotence. Following injection treatment for one year sexual desire and potency had returned.

On examination the patient presented none of the endocrinologic stigmata of pituitary disease. Visual acuity was 20/50 on the left and 20/70 on the right. Ophthalmoscopic examination revealed optic discs within normal limits. There was weakness of the left internal rectus muscle with defective convergence of the left eye. The deep reflexes were generally suppressed with normal abdominal and plantar responses. Perimetric visual fields revealed a bitemporal hemianopsia.

Laboratory examination of the blood, urine, and spinal fluid was negative. The basal metabolic rate was −13.

Roentgenograms of the skull revealed a markedly enlarged sella turcica with evidence of atrophy of the floor and dorsum sellae. There was atrophy of both anterior and posterior clinoid processes.

The patient was given roentgen therapy to the pituitary region from June 4, 1941, through June 20, 1941. During this interval he received 800 r to each of three fields. At the completion of therapy the visual fields were unchanged but the acuity in the left eye improved to 20/30. Following the first series of treatment the patient was given a second course between July 23, 1941, and August 18, 1941, during which time 2400 r were applied. During this series the visual fields showed progressive enlargement. Perimetry done on September 16, 1941, revealed normal visual fields. Since then the patient has remained well and the visual fields have been maintained without further therapy.

Case 2.—B. C., a 47 year old housewife was first seen on March 8, 1943, because of blurring of vision in her left eye of six months duration. For two years she had noted headaches which were usually occipital but occasionally frontal. These had gradually increased in severity until they were present almost daily.

On examination the patient presented a normal physical appearance. The pupils were equal and reacted normally to stimulation. Visual acuity was 20/20 on the right side and 20/50 on the left. The

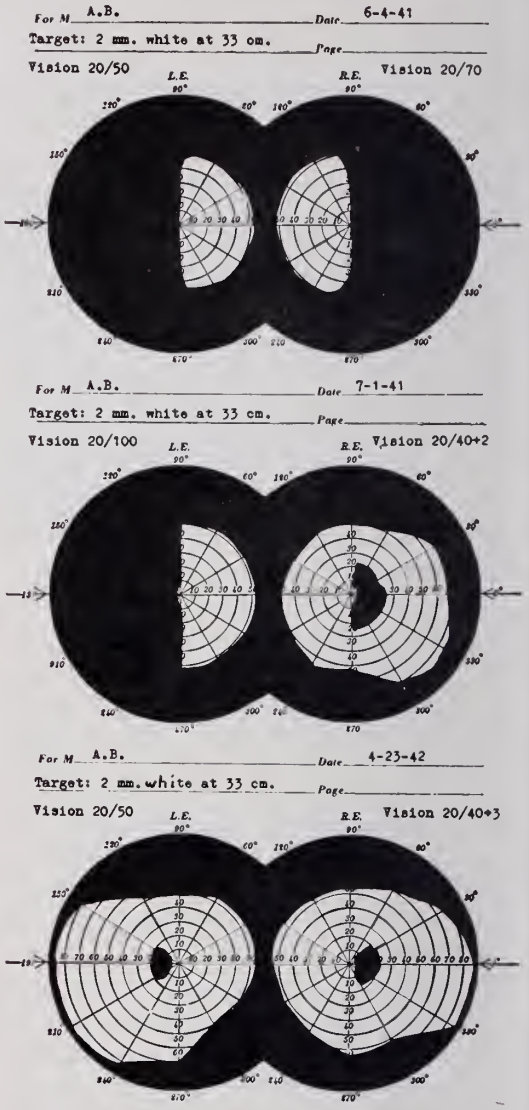

Fig. 1.—Illustration of Case 1.

right optic disc showed temporal pallor and the left was generally pale. Visual fields revealed a complete temporal hemianopsia of the left eye and a small sector defect in the superior temporal quadrant of the right eye.

Roentgenograms of the skull revealed a general enlargement of the sella turcica with some atrophy of the anterior and posterior clinoid processes, especially on the left side.

The patient was given a course of roentgen therapy to the pituitary region starting March 15, 1943, and ending April 1, 1943, a total of 1500 r being delivered to each of three fields. During the course of therapy the headaches disappeared and have not recurred to the present time. After three or four treatments visual acuity began to improve.

The visual fields in August, 1943, revealed a normal field in the right eye and enlargement of the field temporally in the left eye. The patient did not again return for examination until June, 1944, at which time the visual acuity in the left eye had improved to 20/25 and the visual field showed further enlargement temporally. A second course of roentgen therapy was administered beginning July 7, 1944, and ending on August 2, 1944. A total of 800 r was delivered to each of two fields. Examination of the visual fields on September 29, 1944, showed even further enlargement of the left field temporally. Acuity in the left eye improved to 20/25.

Case 3.—A. F., a 37 year old defense worker, presented himself for examination on March 14, 1944, because of severe headache and blurring of vision in the left eye of two and one-half years duration. The headache had been intermittent in nature. In April, 1943, his visual acuity was reported as 20/20 in each eye. Soon thereafter he noted a gradual diminution of vision in the left eye. He also gave a history of sexual impotence of eleven years duration but stated that prior to that time sexual power had been normal. He had been married thirteen years but no children had issued from the union.

On examination the patient did not present the picture of endocrine dysfunction. He was tall but well proportioned. Hair was normal in amount and distribution. Visual acuity was 20/20 on the right and 20/200 on the left. The left pupil was larger than the right and reacted sluggishly to direct stimulation. Opthalmoscopic examination revealed bilateral temporal optic atrophy more marked on the left side. Visual fields showed a complete temporal hemianopsia of the left eye and an upper temporal defect of the right eye.

Roentgenograms of the skull revealed enlargement of the sella turcica only on the left side and absence of the left anterior clinoid process. The right side of the sella appeared to be intact. These findings were consistent with an intra-sellar mass expanding upward and to the left.

Roentgen therapy was applied to the region of the pituitary beginning March 24, 1944, and ending April 21, 1944. A total of 1500 r was delivered to each of two lateral portals. During the course of therapy visual acuity in the left eye improved to 20/100 and there was definite enlargement of the peripheral fields of both eyes, but especially of the left. Headache disappeared and soon after completion of the first course of therapy the patient's sexual potency returned. A visual field examination on April 29, 1944, five weeks after institution of therapy, showed further improvement in the temporal field of the left eye. A second course of roentgen therapy was administered to the pituitary region beginning on July 14, 1944, and ending on August 15, 1944. A total of 1000 r was administered to each of the original two fields. Visual field examination on September 11, 1944, showed further enlargement of both fields temporally. Visual acuity in the left eye was now 20/50. The patient has been free from headache and impotence has been completely corrected.

Discussion

Many authors now recognize that pituitary adenomas can be treated solely by deep x-ray therapy. Others, however, still believe that every case with visual impairment should be subjected to surgical decompression of the chiasm. In a recent textbook[1] of neurologic surgery published in 1942, the following statement is made: "It is our custom to employ deep roentgen therapy following operation and this is started as soon as the operative wound is well

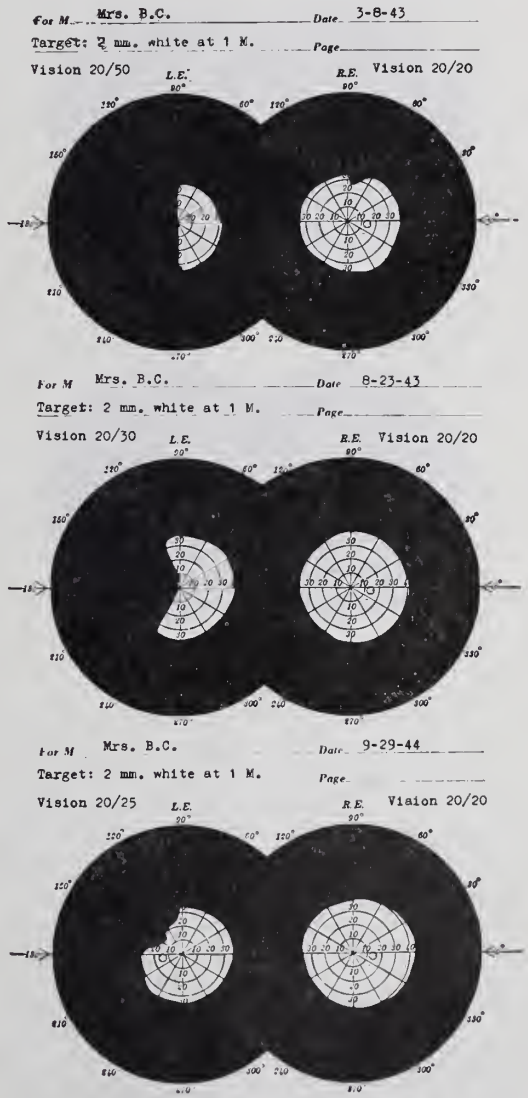

Fig. 2.—Illustration of Case 2.

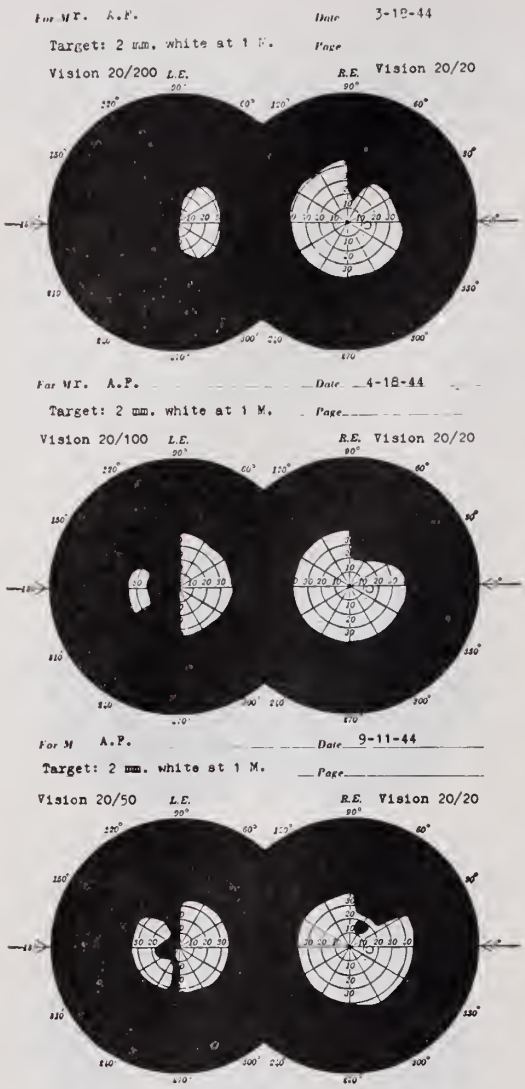

Fig. 3.—Illustration of Case 3.

healed. We do not believe in the use of radiotherapeusis as a substitute for surgery."

Historically, Gramegna[2] (1909) was the first to treat a case of pituitary tumor with roengten rays. His patient was an acromegalic who showed only temporary improvement. In that same year Beclere[3] recorded a case in which headaches and visual disturbances were improved by irradiation to a pituitary adenoma. In a follow-up report twenty-two years later he stated that the patient was in excellent health. Since these initial reports there have been many others, but most of these have dealt with the postoperative treatment of these tumors by radium. A significant case report was that of Smith[4] in 1924, who treated a patient with a pituitary adenoma that had produced a bitemporal hemianopsia and a visual acuity of 20/100 in each eye. Within ten months of institution of x-ray therapy the acuity had improved to 20/50 in the right eye, and 20/40 in the left eye, while the peripheral fields had become practically complete.

In 1925, Dott and Bailey,[5] both neurosurgeons, published a monograph on pituitary tumors which was primarily a clinical and pathologic study of 162 cases from Doctor Cushing's series. In discussing the place of x-ray therapy in the treatment of these tumors they stated: "To summarize the treatment of hypophyseal adenomata we advocate a trial of x-ray therapy, unless there is imminent danger of loss of vision, when a sellar decompression should be done forthwith. During the course of treatment the progress of events should be carefully controlled by repeated perimetric examination. If visual impairment becomes greater operation should be carried out, with partial removal of the tumor. Following all these measures, x-ray treatment should be given in the hope of retarding the further growth of the tumor." Yet in 1932, seven years after this publication, Doctor Cushing[6] himself boldly stated: "So far as concerns radiotherapeusis, at least in the chromophobe adenoma, it is safe to say that it will come to be discarded." In the meantime reports were appearing in the literature emphasizing the effectiveness of roentgen therapy not only in the chromophil tumors but in the chromophobe as well. Thus Guarini[7] in 1925, showed beneficial effects from irradiation in 4 cases, one an acromegalic and three of the chromophobe type. Not only did he show improvement in visual fields and acuity but also in correcting diminished libido in men and amenorrhea in women.

In 1931, Dyke and Gross[8] reported on the roentgen treatment of 5 cases of pituitary adenoma. Four of these presented the clinical picture of chromophobe adenoma. In every case headache was entirely relieved. In 3 of the cases there was improvement in the fields of vision and visual acuity. In the remaining cases, although there was no improvement, there was no further loss of vision.

In 1936 Dyke and Hare[9] reviewed 63 cases of pituitary tumor of which 25 were chromophil adenomas with acromegaly and 38 chromophobe adenomas. They emphasized chiefly the effect of x-ray therapy on the visual fields and acuity. The average follow-up period was four years. Of the 25 patients with acromegaly 19 or 76 per cent showed either an interruption in the progress of the disease or definite improvement. Twenty-four per cent showed progression of symptoms referable to the chiasm in spite of radiation therapy. Of the 38 chromophobe adenomas 26.4 per cent showed moderate to marked improvement, 26 per cent were unchanged, and 47.3 per cent became worse.

Henderson,[10] reviewing 338 cases of pituitary adenoma operated upon by Doctor Cushing, attempted to show that surgery was more beneficial than roentgen therapy. Even in this series, it was discovered that recurrences of symptoms in the sur-

gically treated cases was much greater in those cases which did not receive postoperative radiation. The conclusion was that irradiation following surgical treatment, even in chromophobe adenomas, was distinctly beneficial.

That prolonged benefit can be obtained in treating chromophobe adenomas by irradiation alone has been demonstrated by numerous investigators including Schnitker,[11] Rand and Taylor[12] Pfahler and Spackman,[13] Sosman,[14] and Dyke and Hare.[9] The most recent report is that of Kerr and Cooper[15] in 1942. Of 25 cases of pituitary adenoma treated by irradiation, excellent results were obtained in 56 per cent, good results in 20 per cent, and poor results in 24 per cent. They concluded from their study that x-ray therapy was the treatment of choice in pituitary adenomas.

In the 3 cases presented in this report radiotherapy was the sole form of treatment. The cases were all of the chromophobe type. Headache, which was a prominent symptom in each case, disappeared early. In all cases there has been moderate to marked improvement in the visual acuity and perimetric visual fields. In case 3, impotence, which had been present for eleven years, was corrected. All of the patients are now leading normal useful lives.

The argument for roentgen therapy is certainly strengthened when one reviews the mortality statistics of the two types of treatment. In the average neurosurgical clinic the case mortality for surgical treatment of pituitary tumors would run around 10 to 15 per cent. Davis[1] reports a case mortality of 16.6 per cent in 54 patients. In the hands of Doctor Cushing, who undoubtedly had the most extensive surgical experience with pituitary adenomas, the case mortality was reduced gradually so that in the last three years of his surgical activity it was down to 6.8 per cent. This a remarkable record, but when it is compared to practically no mortalities following radiation therapy, a mortality rate of even 7 per cent can not be set aside without comment. In view of this sizable mortality rate and the fact that most of the eosinophilic adenomas and at least 50 per cent of the chromophobe adenomas show good results with x-ray therapy alone, it seems logical that the least hazardous form of therapy be tried first, and surgical decompression of the optic chiasm be limited to those cases which fail to respond to conservative treatment. This is the plan of attack that is being adopted in most of the major neurosurgical clinics today. The practice is to try radiation therapy first. While this is being done the patient should be under close observation with frequent examinations of the visual fields and visual acuity. If this treatment causes an arrest of the visual loss, even though no improvement, the case should be continued on further courses of irradiation. If, in spite of a complete course of roentgen therapy, the visual fields and acuity show continued diminution, surgical decompression of the optic chiasm should be done immediately and radiation therapy should be applied postoperatively. Those patients who, after one series of irradiation, show definite improvement should be continued on further courses of irradiation. The program, as outlined, calls for close cooperation between the radiotherapist, the ophthalmologist, and the neurosurgeon. It is the job of the neurosurgeon to evaluate the results of conservative therapy and to be ready to step in if this form of therapy fails.

Cases 2 and 3 were treated by Dr. A. Melamed, formerly head of the department of radiotherapy, Mount Sinai Hospital, Milwaukee.

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Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Liabilities in the Indiscriminate Use of Curare

Within the past few years various reliably standardized extracts of curare have become available for clinical use in conditions in which diminished skeletal muscle power is deemed desirable. Clinically, curare has been used for obtaining adequate muscular relaxation during upper abdominal surgical interventions, during thoracic surgical procedures, to aid in bronchoscopic examinations, and to relieve muscular spastic conditions and the convulsions of tetanus and shock therapy. The use of curare in poliomyelitis has been commented upon in these columns quite recently. Its employment in dysmenorrhea has been reported upon within the past few months.

Such a multiplicity of suggestions for its usage indicates an extensive employment of a quite dangerous compound. It is also a known fact that many doctors delegate its administration to subordinates, including nurses and technicians. Since the intravenous route of administration usually is chosen, such a delegation of power is initially illegal. That is not, however, the most serious hazard. Rather, the marked physiological impairments of circulation and respiration which may be brought about under the hands of persons not adequately trained either to recognize or care for such upsets are to be particularly decried.

Marked respiratory depression during anesthesia may lead to such a deficient oxygenation of tissues, particularly those of the central nervous system, that permanent mental impairment develops. There also is the definite hazard, with reduced aeration, of a marked increase in small to massive atelectatic areas of the lungs. Such a condition may well lead to an increased postoperative morbidity and mortality. Where adequate postoperative hospital records have been kept these facts have become more and more emphasized as enthusiasm for the use of curare-like drugs has increased. Actually, death by complete skeletal muscle paralysis may occur. The muscles of respiration are the last group affected by curare and hence peripheral respiratory failure is its mode of causing death.

Experimentally, it can be shown very easily that at each administration of curare there is some decrease in blood pressure. The more rapid the administration of the drug the more sharp the decline and the slower the recovery of the pressure. If 2 mg./Kg. is injected intravenously into a dog in 30 to 60 seconds, the period of time usually employed for the clinical administration of a dose of curare, blood pressure values may decline to one-half or less of the pre-injection level. An occasional animal may be killed by such a procedure.

Fortunately, man usually does not develop a fall in blood pressure when curare is employed. As wider usage of the drug has been made, there have occurred occasional cases, however, in which the blood pressure declines in an alarmingly similar manner to the results noted in the laboratory.

Such hazards from reactions of both the respiratory and circulatory systems call for recognition of their potential possibilities each time the injection of curare is contemplated. They also would indicate that only those with adequate medical training should be entrusted with the use of this group of drugs. Then, not only should minimal unfavorable reactions be recognized but there should be immediately available the knowledge for their treatment. Oxygen should always be on hand before curare is injected so that "assisted" or artificial respiration can be administered if there is the slightest suggestion of inadequate oxygenation. Lastly, neostigmine should be provided if the administration of a specific antagonist seems indicated. Due to its potency, it also must be used with great care.—O. S. ORTH, M. D.

Notes on Clinical Pathology

Editors—WALTER H. JAESCHKE, M. D., University of Wisconsin, Madison, and
S. B. PESSIN, M. D., Marquette University, Milwaukee

The Bromsulphalein Test of Liver Function

This test as originally devised[1] requires the intravenous injection of 2 mg. of phenoltetrabromphthalein sodium sulphonate per kilogram body weight followed by a determination of the quantity of dye retained at the end of thirty minutes. Within recent years the procedure has been made more sensitive and reliable by a correction of normal standards and by an increase in the amount of dye used to 5 mg. per kilogram of body weight.[2]

It should be noted that the test is not accurate in the presence of appreciable degrees of jaundice (an icterus index above 20 units).

The test has an excellent reputation *when properly used* and compares favorably with Hanger's cephalin-cholesterol flocculation test and Quick's hippuric acid synthesis test. In fact, some workers believe that in the absence of appreciable degrees of jaundice, it is the best of the many liver function tests devised.[3]

Procedure

(1) Weigh the patient. It should be noted for convenience that the body weight in pounds divided by 22 will give the number of cc. to inject of the commonly used 5 per cent solution of dye.

(2) Withdraw 5 cc. of blood in a dry syringe as a control. With the blood needle in place quickly change syringes and slowly inject the dye, taking at least one minute to complete the process. Extravascular leakage must be avoided.

(3) Exactly five minutes after completing the injection withdraw with a dry syringe a 5 cc. sample of blood from the other arm.

(4) Take the third specimen of blood exactly 40 minutes later (45 minutes after the injection of the dye).

(5) Allow the blood specimens to clot, centrifuge and pipette 2 cc. of serum from each into separate test tubes.

(6) Clear the control serum by adding 1 drop of 5 per cent hydrochloric acid.

(7) Add 2 drops of 10 per cent sodium hydroxide to the other sera. A red-violet color develops in the alkalinized serum if dye is present.

Preparation of Standards

(1) Dissolve 10 mg. of bromsulphalein (Hynson, Westcott and Dunning, Baltimore, Maryland) in 100 cc. of distilled water, alkalinized with 0.25 cc. of 10 per cent sodium hydroxide. This represents a 100 per cent standard.

(2) Prepare a series of standard tubes ranging from 5 to 100 by diluting the above solution with alkalinized water. Sealed standards keep well for several months if kept in the dark. The numbers on the tubes indicate the amount of dye retained as per cent of amount of dye injected.

Tube	*Dye*	*Alk. Water*
5	0.25 cc.	4.75 cc.
10	0.55 cc.	4.50 cc.
15	0.75 cc.	4.25 cc.
20	1.00 cc.	4.00 cc.
30	1.50 cc.	3.50 cc.
40	2.00 cc.	3.00 cc.
50	2.50 cc.	2.50 cc.
60	3.00 cc.	2.00 cc.
70	3.50 cc.	1.50 cc.
80	4.50 cc.	1.00 cc.
100	5.00 cc.	0

Reading

(1) Place standard tubes in the rear of an ordinary comparator block and place control serum tubes in front of them.

(2) Place alkalinized specimen tube in the rear with a tube containing distilled water in front of it.

(3) Match the color developed in the specimens against the standard tubes.

Discussion

(1) The 45 minute specimen should contain no dye.

(2) Below 50 per cent retention in the serum indicates slight to moderate hepatic impairment.

(3) 50 to 80 per cent retention indicates moderately severe hepatic impairment.

(4) 90 per cent or higher retention indicates very severe hepatic impairment.

(5) A poor surgical risk is indicated by a retention of over 50 per cent.

(6) Occasional patients receiving the 5 mg. per kilogram dose of dye have reactions consisting of transient headaches, a feeling of faintness, and in some cases a chill. These symptoms tend to occur from 45 to 60 minutes after the injection of the dye. No unfavorable after-effects have been demonstrated.

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—WALTER H. JAESCHKE, M. D., *University of Wisconsin.*

As It Looks From Nebraska

Wisconsin is but one of many state, area, or specialty medical societies. Its perspective is that of a mid-western state. But its problems, at least in part, are also problems elsewhere. These pages are provided periodically for the reactions of medical leadership in other parts of the country.

M. C. SMITH

Mr. Smith, who has been executive secretary of the Nebraska State Medical Association since October 1, 1935, formerly served in the journalism field as a Nebraska newspaper owner and publisher.

AS IT looks from Nebraska, the medical profession has an unrecognized number one problem —the threatened extinction of the general practitioner. For many years the trend of medicine has been progressively toward specialization and more specialization. The seriousness of this situation is more evident in the rural areas and smaller towns. Older men are retiring, or are removed by death, and are not being replaced by younger men. This is a blow at the very foundation of medicine.

Specialization has been glorified as the only means by which the individual can acquire proficiency. During his years in medical school the embryo physician receives his instruction, for the most part, from men in specialized fields. He notes the fine office of the specialist and the many advantages of a city practice in one of the specialties. By the time he reaches his senior year in medicine he is inspired by the profound veneration in which the specialist is held, is fired with ambition to emulate the great man of medicine, and dreams that he, too, shall some day become a specialist in some field and receive the homage of his colleagues. The thought of general practice in a small town is almost repulsive. The point has nearly been reached at which the admission of being a general practitioner, especially in a rural community, is paramount to an admission of lack of ability. The war seems to have accentuated the condition, and the problem of relocating the returned veteran is a difficult one.

Many of the cities now have a greater number of physicians than they had before the war, and the smaller towns are understaffed or are without physicians, although they present excellent opportunities for the young man to develop a lucrative practice. These towns need doctors and the citizens are anxious to cooperate in any way possible to make their community attractive as a location. It is true that many of these locations do not have hospitals, nor the social and club advantages of a city, but they do afford advantages and opportunities not found in the larger centers. For the most part the elementary and secondary schools provide good educational advantages for the doctor's family, and living conditions are excellent. A number of these towns are becoming hospital-conscious and will work with a young physician to provide these necessary facilities.

Because of their inability to bring medical care to their people, many of these communities are now looking to the federal government for relief, and no doubt not a little of the support for federalized medicine originates from this source.

This problem needs the attention of organized medicine, and without too much delay. The answer might lie in the establishment of one year internships in general practice under the supervision of an established physician or group of physicians. Another solution might be to require one or two years of general practice as a prerequisite to specialization. Either of these methods would add appreciably to the background of any physician and would answer a definite need in the field of general practice. The problem might be solved, at least in part, by pointing out to the young physician that there are many advantages in a rural practice which he will not find in a city practice. His patients are neighbors and friends. His social and civic standing is the highest possible. Great courage and ingenuity are required to practice good medicine without adequate hospital facilities, modern diagnostic equipment, and a corps of willing assistants and nurses on call at all times. Herein lies a challenge to high ability. This is not a field for the weakling. Many of our better physicians are doing it successfully and are happy in their work. The material rewards, as well as the satisfaction in a job well accomplished, appear commensurate with the service rendered.

Some means *must* be devised to provide a better distribution of doctors and more medical care to the rural areas.—M. C. SMITH, *Nebraska.*

. . . . THE PRESIDENT'S PAGE . . . .

The Progress Road

CERTAIN periods of history have been comparatively peaceful; and there have been times of outcry and agitation. The years of unrest find sophists, agitators and false prophets exhorting for sudden, drastic changes in the ways of life and living. Progress road is often a slow, rough thoroughfare because true advancement is usually attained by trial and error. Study and thought should always precede law making, speech making, and column writing. I shall cite a few examples of error and inconsistency by eminent men currently attempting to discourse on the unfamiliar.

Heard at the Senate Committee's hearing on the Wagner–Murray–Dingell bill. Senator Murray: "Is it not true, Mr. Green, that most of the eye defects in the country occur at the time of birth?"

Mr. Green (President of the American Federation of the Labor): "That is what I say."

Senator Murray: "Due to inadequate attention?"

Mr. Green: "Most of the eye troubles occur during the infant period many times, and sometimes during the birth period."

President Truman, speaking at Washington College on June 1, said: "America is facing the greatest age in its history. Its government never will come under the absolute control of any one man or any one group of men. I have said time and again that I would much rather see a thousand insurance companies with four million dollars in assets than one insurance company with four billion. I would rather see a hundred steel companies than one U. S. Steel Corporation. I would rather see a thousand banks than one National City Bank." But when he talked of the relatively unfamiliar, he indorsed Bill S. 1606 that would make the Surgeon General of the Public Health Service the "big shot" over the whole field of medicine.

Bill S. 1606, (Wagner–Murray–Dingell bill) is divided into two parts. Title I deals principally with the granting of federal aid to states for the control of tuberculosis and venereal diseases, and, also for the promotion of maternal and child welfare.

Title II deals with prepaid personal health service benefits and is the more controversial of the two titles.

In the Senate Committee hearing on this bill, Rev. Alphonse M. Schwitalla, head of the Catholic Hospital Association, appeared as a witness. He generally agreed with the objectives advocated in Title I, but did not approve of the plan for securing these objectives outlined in Title II. I quote the newspaper report of his testimony: "The Rev. Alphonse M. Schwitalla, president of the Catholic Hospital Association, also indorsed in a prepared statement the bill's objectives. He suggested that Federal aid be extended to private as well as public health service organizations."

This news item was released by the reputable A. P. service and did not emanate from the foggy brain of a fifth rate columnist. The inadequacy of the report was due to the correspondent attempting to cover an unfamiliar field.

These examples should impress the medical profession with the importance of educating the general public in the scope and character of the doctor's work. The profession and public should understand that people may not differ on objectives but may not agree at all on the manner of securing them. What battles are fought over plans for the general welfare and the pursuit of happiness!

P. R. Minahan, M. D.

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« « « EDITORIALS » » »

Introducing Senator Robert A. Taft, the Guest Editorialist

R. A. TAFT

DESCENDENT of a long line of leaders in civic activities and public life in Ohio and in the nation, Robert A. Taft, Senator from Ohio, has devoted his career largely to public service, consistent with his family traditions first established by his grandfather, Alphonse Taft, Secretary of War under President Grant and later Attorney General of the United States, and of his father, William Howard Taft, twenty-seventh President of the United States, and Chief Justice of the United States Supreme Court.

Senator Taft's graduation from Yale and from the Harvard Law School preceded his work as Assistant Counsel of the Food Administration during World War I, and as Counsel of the American Relief Administration in Europe for several years following the war. Election to the Ohio House of Representatives in 1926 began his political career, succeeded by election to the Ohio Senate in 1930, nomination as first choice candidate of Ohio for the Republican presidential bid in 1936, election to the United States Senate in 1938, and 1944 re-election.

Participation in many Senate committees, among them the Banking and Currency Committee, the Education on Labor Committee, and the Special Committee on Post-war Economic Policy and Planning, is now added to this busy Senator's activities.

Mr. Taft, Ohio's Senior Senator, has shown great interest in legislation affecting men in military service, as his four sons, all of whom served on active duty in World War II, presented him with first-hand appreciation of the hardships and sacrifices endured.

The Wisconsin Medical Journal offers with pleasure Senator Robert A. Taft's editorial, written exclusively for presentation in this issue.

An American Plan

PRIMARY public responsibility for the health of the people should rest on the states and on local governments. This is most important to those of us who are concerned with freedom in this country. Medical care must be a local and state concern. Federal funds are necessary, but only to aid the lower income groups of the population and furnish financial assistance to states and local governments to supplement the limited funds available for help.

This plan is an American plan based on assistance to the needy, liberty to the individual, and a free medical profession. Only by retaining such freedom can we hope to go forward with the progress in medicine and health for which America has been noted. That is why Senators Joseph H. Ball, Rep. (Minnesota), H. Alexander Smith, Rep. (New Jersey), and I have introduced a health bill (S. 2143) which proceeds on a fundamentally different philosophy from that of the two social insurance bills now before Congress which were introduced by Senators Robert F. Wagner, Dem. (New York), James E. Murray, Dem. (Montana), and Representative John D. Dingell, Dem. (Michigan).

Our bill proposes that all of the scattered health activities of the Federal Government be put together in a new independent National Health Agency to be headed by an outstanding physician. It is based on the extension of Federal aid to the states to enable them to give comprehensive hospital and medical service to every American unable to pay the full cost of such service.

Federal aid amounting to $200,000,000 a year for general medical and surgical service, and $20,000,000 a year for dental service is authorized by the bill, but with complete control of administration under state and local governments.

The new measure encourages the formation of voluntary health insurance funds, and also provides money for research, and grants-in-aid for research. It is intended entirely to replace the Federal compulsory sickness insurance program proposed by Senators Murray and Wagner, and Representative Dingell.

We would prefer to see the Health Agency a department of the government with a representative in the Cabinet, but we feel this might create opposition to the vitally important job of consolidating health activities under an independent agency.

Our bill proposes that as a condition of obtaining Federal aid, each state shall make a comprehensive survey of the health activities throughout the state, both public and private, urban and rural, with special reference to the medical care provided for the lower income groups. Based on this survey, the state must propose a plan by which hospital service and medical service in hospitals and clinics are made available to all families and individuals unable to pay for such services. In short, the plan must fill up the gaps which now exist in such sections. The hospital bill will promote the construction of rural hospitals, and will add medical service.

The bill further provides that a state may use Federal money together with its own funds to encourage the formation of voluntary health insurance funds by paying to such funds the premiums required for those low income families and individuals unable to pay

for insurance themselves. A state plan may thus provide medical care directly, or through a fund such as the one which has been successfully operated in Michigan.

The encouragement of such voluntary funds will also make available, to those middle income families who desire it, insurance against serious illness, the expense of which they might find impossible to meet in a single year.

The bill also requires state plans to provide for the periodic medical examination and the periodic dental examination of all children in public and private, primary and secondary schools. Lack of such examination led to neglect of many of the remediable defects which were responsible for the high rejection rate in the draft. This examination will be without charge, but free treatment will be given only to those whose families are unable to pay for it, or for insurance which might cover it. Federal funds may be used for some additional services at the option of the state.

In addition, the bill provides further funds for research, particularly in the fields of dental health and neuropsychiatric problems. It authorizes buildings for such research.

Also, under the new proposal, any Federal employee who wishes to join a voluntary health insurance fund may direct the government to deduct the necessary sum from his pay and apply it directly to the fund. The government today is the only employer who will not accept such direction.

The Wagner–Murray–Dingell bill endorsed by President Truman (on which hearings are now taking place) proposes Federal compulsory sickness insurance. All classes of the population would have to pay for this insurance, in the form of payroll taxes or otherwise, so that a huge sum amounting to from three to five billion dollars a year would pour into Washington. The government would then have to set up a vast administrative organization with thousands of personnel to police the insurance system and to supervise and pay all the doctors in the United States. In effect, health service would be nationalized. A Federal bureau could tell everyone when he could have a doctor, how often the doctor would call, and whether the patient could have a specialist. Every detail of medical service would be regulated from Washington.

Our proposal follows the theory that the United States already has a comprehensive medical service, as good as any in the world, but that there are gaps in that service, particularly in reaching the lower income groups. Our bill encourages and assists every state to fill up these gaps, building upon the existing foundation. Free service will be furnished to those unable to pay. Voluntary health insurance plans will be encouraged so that health insurance may be available to the great numbers of those who desire it, without forcing any one, patient or doctor, to abandon his present practices.

Above all, the bill places the primary responsibility for the health of the people on the states and on local governments where it belongs.

NURSES AND TUBERCULOSIS

If it is recognized that from .5 per cent to 2 per cent of patients admitted to general hospitals have roentgenologically demonstrable significant tuberculosis of the lung, one is obligated to consider the implications of this state of affairs. The assertion covering the incidence of tuberculosis in general hospital admissions is based upon reports gathered from various parts of the country. This being so, it is imperative to make adequate arrangements accordingly. Because open cases of tuberculosis require immediate isolation and treatment, and because they are sources of spread of the disease, the following pertinent points deserve special attention:

1. Unless tuberculosis in the communicable stage is recognized promptly, it may represent a danger of infection to other patients with whom the tuberculous individual is allowed to be in close and continuous contact.

2. Finding open cases of tuberculosis in general hospital admissions obligates one to search for the source of origin of the disease and to prevent its further spread in the community.

3. When active cases of tuberculosis are undiagnosed while under treatment in a hospital for some condition other than tuberculosis, the medical staff is bound to be unnecessarily exposed to the danger of infection. The same holds true of instances where known cases of open tuberculosis are admitted but no effective measures are taken for the protection of those in attendance.

4. The same situation pertains to members of the nursing staff, nursing students and attendants.

5. In addition to general hospitals, all other health institutions, such as tuberculosis sanatoriums, mental hospitals, sanitariums, other specialized hospitals, dispensaries, and clinics come under the same consideration.

It is a well established fact that the incidence of tuberculosis is higher in nurses employed in general hospitals than in women of the same age groups who are engaged in other work. This indicates that tuberculosis is an occupational hazard in nurses. If this is so, one should be aware of a triple responsibility which the medical profession and hospital administrative authorities must automatically assume.

1. Nurses engaged in hospital work should be protected from undue exposure to tuberculous patients.

2. Nurses must be protected from tuberculosis of other nurses who already developed this disease through contact with patients or otherwise.

3. Provisions should be made for compensation wherever, disability due to tuberculosis is recognized as an occupational disease, as in Wisconsin since July, 1919. Undoubtedly, these items require special thought and effort, but time and money invested in preventive measures are richly repaid by avoiding the spread of infection and the development of tuberculosis with its necessarily prolonged treatment, and also by saving funds which otherwise would be spent on compensation claims for disability or death due to tuberculosis.

The approach to the effective solution of these problems entails a number of means and ways.

1. Inasmuch as active tuberculosis oftentimes exists without manifest symptoms, all patients entering a general hospital should have a chest roentgenogram. The chest film should be interpreted promptly. If there are pulmonary changes suggestive of tuberculosis, additional studies (tuberculin test, bacteriologic examinations, including fasting gastric contents) should be carried out.

2. Patients in whom active tuberculosis is discovered in this fashion, as well as patients who are admitted with tuberculosis evidently in the communicable stage, should be isolated from other patients. Each general hospital should have a ward or sufficient number of rooms available for this purpose.

3. Tuberculous patients so isolated must be cared for according to rules and regulations pertaining to the management of contagious diseases.

4. The same considerations apply to mental institutions and other specialized health units.

5. All nurses and attendants employed in institutional work should have a chest roentgenogram. This should be followed by adequate diagnostic investigations in case the chest film reveals changes suggestive of active tuberculosis. The roentgenograms should be repeated periodically at reasonable intervals.

6. All newly employed nurses and attendants should be subjected to similar prophylactic surveys. The frequency of repeated chest roentgenograms is determined by the estimated likelihood of professional exposure to tuberculosis. Physical examination, no matter how thorough, is not a substitute for a chest roentgenogram.

7. All nurses and attendants employed in institutions such as general hospitals and others, should be tuberculin tested. All those who do not react to the tuberculin skin test should be given repeated tuberculin tests every four to six months. When a previously negatively reacting individual becomes tuberculin positive, a thorough examination should be carried out, including X-ray films of the chest, to ascertain the exact pulmonary status.

8. All nurses and attendants employed in health institutions should be thoroughly instructed in the proper handling of tuberculous patients, contaminated eating utensils, bed clothes, and how to avoid droplet infection with tubercle bacilli.

9. Students entering schools of nursing should have the same careful examination on entrance and periodically during their stay as that outlined for nurses.

Only when the active science of tuberculosis and the technic of prevention are properly taught and used in a well-coordinated, efficient manner by nurses, physicians and hospital administrators, shall the general hospital together with all other health institutions be able to discharge its responsibility to its nurses and to the public.—A. V. C.

As It Looks to Your State Board of Health

(These timely discussions of health problems are prepared by staff members as a special service to Wisconsin's physicians.)

Tinea Capitis

From recent reports, ringworm of the scalp caused by the Microsporon audouini is gradually spreading over the United States. In recent months cases have been recognized in various communities in Wisconsin. In one community the rate of proved cases was 4.4 per cent of school children under 16 years of age.

Tinea capitis, sometimes called grey patch ringworm, is limited to young human beings. It infects the scalp, usually first the occiput. The infection usually attacks boys, causing a patchy baldness which generally clears up spontaneously at puberty. It is spread from child to child through close contact and probably through inanimate objects, e.g., the backs of chairs and benches, used by the general public, tumbling mattresses in gym classes, caps, hats, and combs.

The infection is first recognized by a small circumscribed area on the scalp covered with a cigarette-like ash. Shortly after this the hair in this area becomes dry and as though dead, and breaks off. These stubby ends are paler, are usually loose and can be pulled out easily with tweezers. Generally there is no itching, irritation or inflammation as is often the case with other types of ringworm. The most efficient method of finding cases is probably through school surveys up to ninth grade, followed by surveys of preschool siblings. Use of the Wood Light (filtered ultraviolet light) shows, in a darkened room, a clear greenish-blue fluorescence of the infected hair near the scalp. Since ringworm common to the cat and dog (Miscrosporon lanosum) may also infect the human being, and also produces fluorescence, it is necessary to culture a little of the infected hair. Microscopic examination of the culture establishes diagnosis of the infection. Cattle ringworm (T. gypseum) also infects the human being, generally with considerable local reaction, but fluorescence is not produced. The State Laboratory of Hygiene, Madison, and the Branch Laboratory at Rhinelander, are equipped to make these cultural studies for the physicians of the state.

The State Board of Health has ordered a portable Wood Light for diagnostic purposes. It will be available to physician health officers or to school physicians who wish to survey their school population. The use of the Wood Light will frequently locate cases previously missed on the usual inspection.

The infection produces no systemic symptoms and there is generally no local inflammation. Consequently, there may be a tendency to overlook the moth-eaten appearance of areas of the scalp, knowing that at about puberty the infection spontaneously clears up. The principal reason for treatment of the condition lies in the fact that each untreated case will probably be the focus of a long line of secondary cases. Failure to isolate and treat early cases would probably result in an endemic infection which most of our young boys would contract.

Under the present rules of the State Board of Health, the child with ringworm is barred from school.

Treatment has been exceedingly varied, and from most reports, generally unsuccessful except for deep x-ray of epilating dosage in the hands of the well trained and experienced roentgenologist or dermatologist.

Studies on various fungicides are now under way, but until there is something more successful than is now available the treatment of choice remains x-ray.

The State Board of Health will be interested in receiving reports of tinea capitis cases from practicing physicians, and offers cooperation in epidemiologic studies of the infection.

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1. Lewis, G. M., and others: Measures to prevent and control epidemic of ringworm of scalp, New York State J. Med. 44:1327–1333 (June 15) 1944.
2. Lynch, Francis W.: Ringworm of the Scalp (Tinea Capitis), The Journal-Lancet 65:228–229 (June) 1945.

—Frances A. Cline, M. D., *District Health Officer, District No. 8.*

Looking at Sickness Insurance Abroad

By J. G. CROWNHART

Just prior to his death in Cleveland in 1941, J. G. Crownhart, Secretary of the State Medical Society of Wisconsin, addressed the Health and Accident Underwriters Conference in Chicago on "Looking at Sickness Insurance Abroad." With the current hearings and discussion on the Wagner-Murray-Dingell legislation and the whole subject of compulsory sickness insurance, it seems again timely to present Mr. Crownhart's paper in The Wisconsin Medical Journal. For the convenience of the reader, the whole paper was published in the July, 1941, issue of the Journal. It will be reprinted in installments in current issues of the Journal of 1946, beginning with the June issue and continuing through the October issue.

PART II

(Continued from the June Journal)

Unlike Other Insurances

SICKNESS insurance differs vastly from all other social insurances. Unlike our existing social security legislation for unemployment insurance, old age assistance, old age retirement benefits, aid for dependent children (mother's pension), and aid to the blind, compulsory sickness insurance does not pay out all its benefits in cash with which the beneficiaries may purchase the necessaries of and to life. Like the workmen's compensation acts, the benefits provide for a cash payment to cover a portion of wage loss and a medical benefit. However, under compensation insurance, if the medical service rendered by the insurer is deficient in quality or quantity, the period of disability under which cash payments must be continued is much prolonged; the end disability for which a final award is to be paid, is substantially increased; and in total, there exists a heavy money penalty for the insurer who would furnish an inferior or deficient type of medical care. No such penalty exists under compulsory sickness insurance in which there is no final award for permanent disabilities and in which the period of coverage is relatively so short that a balanced budget can more easily be had by lessening the medical benefits than in any other manner. Nor is there in compulsory sickness insurance that judicial review to establish percentage of disabilities that tends constantly to expose any inadequacies in the medical care afforded the patients.

Secondly, it is to be noted that unlike all other social insurances, in compulsory sickness insurance the event insured against, to a large degree, is within the control of the insured person. We can define unemployment in a law; it is an event that no one wishes to have happen. We can define the conditions precedent for the benefits of old age assistance in terms of both age and limited property ownership. But how can we define illness when it may be of such varying degree, dependent upon so many different factors, and at times actually constitute a welcome temporary or even a more lasting haven or refuge, which of itself may be a form of illness? If the state of good health could be defined, then we would have a basis upon which to say that a deviation constituted sickness,—the event insurance covered. Actually no such definition can be made. One of the marvels to science, on the one hand, is the individual who may deviate greatly from the principles of right living and yet not be aware of ill health, and on the other hand, the "frail" person who outlives all presumably robust members of his family.

Furthermore, there is a constant conflict, always reflected in premium inadequacies, between the administration of compulsory sickness insurance as a protection against an undesired occurrence of a hazard of life, and on the other hand, as a social insurance wherein the greater the usage made of its benefits, the greater presumed health benefits to the nation will be had. The end result is an insured population that thinks of this legislation as constituting the payment for a social health service to be placed in immediate use if possible, while the administrator is faced with supplying benefits computed on an insurance concept.

From the insurance viewpoint, every system insuring against all illness faces what you in this audience long have recognized,—the great administrative difficulties in establishing by term of policy what exactly constitutes an occurrence of the event insured against. How can the administrator distinguish between those who make claims upon the plan because they are ill and those who may make demands wherein relief of pain or disease is not the primary factor?

Limit on Wage Deductions

Again, from the viewpoint of insurance, how may we establish an adequate premium without depriving those in the lower wage brackets from the necessaries of life upon which sound health itself is predicated? How, at the same time by this self-limited premium, may we raise funds sufficient to pay the costs of a partial wage loss and every needed sickness care for all types of illnesses that may be experienced? Unfortunately under compulsory sickness insurance the premium is established in the initial enabling legislation. And, unlike premiums for the voluntary cash insurance, the premium for compulsory insurance may be increased only in theory. I pointed to one reason in the statement that there was a practical limit to how much could be subtracted from pay checks on the one hand, and added to commodity prices by pay-roll taxes on the other hand.

This was well recognized by the International Labour Office when, in a publication in 1938, it stated that "The state,—partly to avoid overburdening the economic system in general and partly because the insured persons cannot spare much by way of contributions out of their meagre pay,—must keep at a comparative low level the regular contributions which it requires to be paid in sickness insurance to cover the insured population against the consequences of sickness and childbirth."

Within the week a press release from the Federal Social Security Administrator, Paul V. McNutt, concerning the National Nutrition Conference for Defense, primarily concerned with how to raise the health standards of our people, quoted Mr. McNutt as stating that in addition to the 15,000,000 persons dependent on public assistance "there are 30 million persons in the low-income group who are economically little, if any, better off than those who are depending on aid from social agencies. Altogether at least 45 million persons today have inadequate diets primarily because their incomes are so low they cannot afford to buy sufficient quantities of dairy products, leafy vegetables, and other vitamin-rich foods."* Is this not proof certain of the validity as to this country of the statement made by the International Labour Office?

And, may I add still another cogent reason why the premium is not raised,—it is politically inexpedient for the legislator who promises for a given pay-check tax that he will provide the necessary benefits in times of illness and as a health service, to return to his people from time to time in the future and say to them, "There was an error in our calculation and we must increase the amount we take from your pay check each week by 25, 50, or even 100 per cent." Nor, in the history of sickness insurance, has this happened.

May I now summarize certain of these findings to this point by stating concisely that in terms of insurance, the event insured against is not susceptible of clear definition. The event insured against, in substantial numbers, is within the control of the persons insured and may actually be one which they will welcome rather than universally resent and endeavor to avoid. As a result, the premium calculation is not susceptible to the formulas of life expectancy tables, and unlike the cash insurances, the premium cost established tends to become a premium fixed for all time in the future.

With this all too brief statement and recital of certain of the legal and insurance technicalities found in all sickness insurance experience abroad, may we now examine compulsory sickness insurance from the viewpoint of the man who is paying the premium.

(To be continued)

* Statement quoted made in 1941.

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THE MARCH OF MEDICINE

Appleton	WHBY	1230 kc.	Saturday	11:15 a. m.
Ashland	WATW	1400	Saturday	8:15 a. m.
Green Bay	WTAQ	1360	Friday	3:45 p. m.
Ironwood, Mich.	WJMS	1450	Saturday	8:15 a. m.
La Crosse	WKBH	1410	Thursday	3:00 p. m.
Madison	WIBA	1310	Saturday	10:00 a. m.
Manitowoc	WOMT	1240	Saturday	4:30 p. m.
Marinette	WMAM	570	Saturday	10:45 a. m.
Medford	WIGM	1490	Friday	11:15 a. m.
Milwaukee	WEMP	1340	Saturday	11:30 a. m.
Rice Lake	WJMC	1240	Monday	3:30 p. m.
Stevens Point	WLBL	930	Monday	11:30 a. m.

The Wisconsin State Medical Golf Association

Thursday, August 15, Oneida Golf Course, Green Bay

Oneida Golf and Riding Club, Green Bay. Eighteenth hole, par 3, 160 yards.

ON SEPTEMBER 20, 1944, a group of members of the State Medical Society met at the Ozaukee Golf Club and organized "The Wisconsin State Medical Golf Association." A tentative set of by-laws was adopted, sufficient in outline for organizational purposes. Temporary officers were elected, with Dr. G. R. Love, Oconomowoc, as chairman, Dr. J. C. Griffith, Milwaukee, vice-chairman, and Dr. E. W. Miller, Milwaukee, secretary–treasurer. The by-laws provided that:

"A life membership in the Association is $5.00."
"There shall be no annual dues."

On this basis quite a number of doctors were contacted, so that by the time of the State Medical Meeting in September the association had over fifty paid members.

On the afternoon and evening of the last day of the State Medical Meeting in Milwaukee, the association held its first annual meeting and banquet. In the tournament, itself, Purtell, Griffith, Conway, and Love were tied for first place. In the play-off Purtell won the low gross championship. Four permanent prizes were awarded in the low gross championship, and four in the low net championship tournament. Various other classifications were set up within the tournament, with a total of thirty-five prizes awarded.

At a business meeting following the banquet, permanent by-laws were adopted. The executive body of the association consists of a board of directors of five members, who in turn elect the officers. The board of directors for 1946 is composed of J. C. Griffith, Milwaukee; G. R. Love, Oconomowoc; E. W. Miller, Milwaukee; E. L. Watson, Ripon; and L. J. Woodhead, Waukesha. The officers are: G. R. Love, president; E. L. Watson, vice-president; and J. C. Griffith, secretary–treasurer.

The association intends to hold two tournaments each year, one at the time and place of the State Medical Meeting, and the other, held in a different section of the state each time, earlier in the summer. This year the summer tournament will be held at the Oneida course at Green Bay, Thursday, August 15. The golfers who have never played Oneida are in for a surprise as this is the most picturesque course in the state as well as one of the toughest.

Mark the date—Thursday, August 15, at Oneida, 1:00 p. m. and reserve the afternoon and evening for golf, fun, and good fellowship.

STATE OF WISCONSIN

No. 53, A, 1943.

A JOINT RESOLUTION

Urging physicians and dentists to maintain records of services rendered to veterans of the present war.

WHEREAS, It is essential to the recovery of federal war compensation by veterans of the present war that a given disability be shown to have resulted from and in connection with the military service of the claimant, and

WHEREAS, It is also essential to proof of such service-connected disability that all treatment records kept by a physician or dentist of the claimant be available to military and federal authorities, and the absence of such a record may defeat the bona fide claim of a veteran; now, therefore, be it

Resolved by the assembly, the senate concurring, That the state board of health, state board of medical examiners, the state board of dental examiners, and the several professional societies be requested forthwith to ask that all practicing physicians and dentists ascertain, so far as possible, whether patients are now or are on any subsequent date veterans of the present war, and that in the case of each such veteran his case history be preserved for at least 6 years after the date the last professional service is rendered by such physician or dentist. Be it further

Resolved, That each of the above boards and professional societies be further requested to contact all of their respective licensees and members at least once a year for the balance of the war, and at least once each year for the first 6 years following the war, so as to remind all such persons of the importance to the war veterans of preserving such professional records; and be it further

Resolved, That duly attested copies of this resolution be transmitted forthwith to such boards and professional organizations.

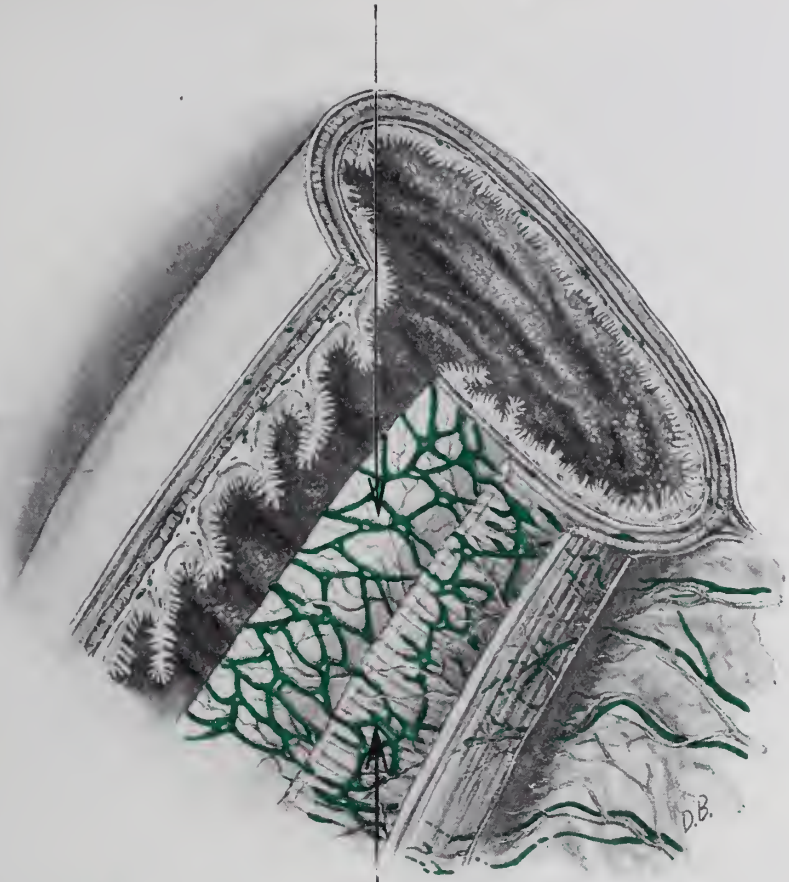
Conrad Shearer — Vernon W. Thomson

PRESIDENT PRO TEMPORE OF THE SENATE. SPEAKER OF THE ASSEMBLY.

Lawrence R. Larsen — Arthur L. May

CHIEF CLERK OF THE SENATE. CHIEF CLERK OF THE ASSEMBLY.

This resolution was introduced by Assemblyman Lyall T. Beggs, of Dane County, a veteran of the first World War and Past Vice-Commander of the American Legion. It will be printed periodically in *The Wisconsin Medical Journal* during the next several years.



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Physicians in Service

For many months material in this section was carried under the title of "The Nation at War." With physicians still entering service, with many returning to reestablish themselves in civilian practice, and with many planning to continue in service for an indefinite time, it is the decision of the *Journal* to continue the section under a more timely title.

Military Notes

Federal Security Agency
PROCUREMENT AND ASSIGNMENT SERVICE
Washington 25, D. C.

To: State Chairmen for Physicians and Dentists
From: Central Office, Procurement and Assignment Service

Subject: Medical and Dental Officers who are Graduates of V–12 or ASTP. While it is recognized that Procurement and Assignment Service Chairmen no longer have any responsibility for the recruitment or the release of medical and dental officers, it is realized that they are still being called upon to give information on the status of recently graduated officers. In this connection the following decision of the Bureau of Medicine and Surgery of the Navy Department will be of interest:

Paragraph 1

A survey of the medical and dental requirements of the Army and Navy shows that a critical shortage of medical and dental officers will exist for some time to come. To alleviate this shortage and to establish comparable discharge criteria for the Army and Navy, certain naval dental officers who are graduates of the V–12 training program and naval dental officers who were educated wholly or in part by the Government will no longer be released to inactive duty under present demobilization procedures.

Paragraph 2

This provision covers all United States Naval Reserve Medical Officers who are graduates of V–12 and who were or will be ordered to active commissioned duty on or after 1 March 1946 on completion of internship (either civilian or Navy). This provision also covers *all* United States Naval Reserve Dental Officers who were educated wholly or in part as members of either V–12 or the Army Specialized Training Program and who have not completed three years of active duty as dental officers.

Paragraph 3

It has been determined that present requirements make it necessary to retain such medical officers on active duty for a period of two years after completion of internship, and such dental officers for a period of three years after reporting for active duty as dental officers. It is anticipated that the needs of the service in the future may permit a reduction of this period.

Paragraph 4

"Existing Navy Demobilization Instructions" are modified to the extent that above designated medical and dental officers are exempt from demobilization and it is directed that all such reserve medical and dental officers who have not been detached under orders directing them to report to a separation center shall be retained at their present duty stations. Separation centers shall retain on board and report to the Bureau of Personnel all such officers who report to separation centers after 30 May 1946 pending specific instructions as to their disposition.

Paragraph 5

All reserve medical officers who upon completion of internship reported for active duty on or after 1 March 1946 shall submit to their commanding officer an affidavit certifying whether they are graduates of the Navy V–12. All reserve dental officers shall submit to their commanding officer an affidavit certifying whether they received any part of their dental education under V–12 or Army Specialized Training Programs. Commanding officers shall not request separation orders for officers ineligible under this Navy Demobilization Instruction nor detach any such officer. Commanding officers shall endorse separation orders of all medical and dental officers with a statement that the officer is eligible for separation under this Navy Demobilization Instruction.

Paragraph 6

Separation centers shall inspect orders of all medical and dental officers and shall insure compliance with the above.

The Office of the Surgeon General of the Army has advised that they will operate in conformity with the agreement with the Navy and that the effect of this agreement on Army officers will be as follows:

Regardless of date of entry on active duty, only a two-year period of service will after 1 July 1946 be required of all Army Medical Corps Officers, including graduates of the ASTP except critically needed specialists.

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Returning Veterans

E. H. PAWSAT

Lieutenant Commander Ewald H. Pawsat, Fond du Lac, who entered the Navy December 7, 1942, was discharged April 2, after serving at the following Naval centers: Red Cross Blood Donor Center, St. Paul, Minnesota; Naval Operating Base, Norfolk, Virginia; Base 2, Naval Hospital, Roseneathe, Scotland; U. S. Naval Advanced Bases at Morlaix, France, and Southampton, England; and the U. S. Naval Hospital, Portsmouth, Virginia.

Lieutenant Commander Pawsat wears the Atlantic Theater and European Theater of Operations ribbons, and has one combat star.

Captain Albert L. Babbitz of Milwaukee, received his discharge from the Army March 10. Captain Babbitz entered military service in April, 1942, and spent twenty-three months overseas.

Lieutenant Commander William H. Bennett of Racine, formerly of Kenosha, who received a discharge recently from the Navy, has opened an office for the practice of ophthalmology in Racine. The doctor entered service July 6, 1943, and served at New Orleans and Metaire, Louisiana, and overseas.

Upon completion of two and one-half years of active duty with the Army, **Major Richard D. Champney** of Milwaukee received a discharge February 15. Major Champney began active duty in August, 1943, and served with the 3d Air Force at Dyersburg, Tennessee, until August, 1945, when he was transferred to Baer Field, Indiana, to the Troop Carrier Command. For the month before his discharge he was stationed at Lauron Field, Georgia.

Following his discharge from the Army as a Major in the Medical Corps, February 21, **Dr. Wilmer H. Christiansen** of Milwaukee has been taking post graduate work at The California Hospital in Los Angeles as a resident in urology. During his time in service Major Christiansen was stationed at Camp Shelby, Mississippi, and El Paso, Texas, among other posts.

Lieutenant Commander David Cleveland of Milwaukee, who reported for active duty with the Navy April 24, 1944, received his discharge recently and has re-opened his office in Milwaukee, practicing neurological surgery.

Lieutenant Commander Paul J. Collopy, Milwaukee, received a discharge from the service February 17, following over three years of active duty with the Navy, including eighteen months spent overseas. Lieutenant Commander Collopy entered the Navy in December, 1942, and was sent to Sampson Naval Hospital, Sampson, New York, for fourteen months. Later he was stationed at the Naval Operating Base, Argentia, Newfoundland. Upon his return to this country in October, 1945, the doctor served in the Naval Hospital, Great Lakes, Illinois, until his discharge.

Lieutenant Commander Collopy wears the American Defense ribbon.

Major James E. Dollard recently reopened his office in Madison following his discharge from the Army Medical Corps. Major Dollard, who entered the service July 12, 1942, served at Liberal, Kansas; Station Hospital, San Antonia, Texas; and Fort Worth, Texas.

Lieutenant Eugene E. Eckstam of Madison, who entered the Navy January 10, 1944, upon completion of his internship at St. Luke's Hospital in Duluth, Minnesota, received his discharge May 23. He is now at Mayo Clinic, Rochester, Minnesota, on a three-year fellowship in surgery.

Lieutenant Eckstam was first stationed at Great Lakes, Illinois. Later he served on the USS–LST 507 and the USS–LST 391, participating on the latter ship in the Normandy invasion. From August, 1944, to March, 1945, the doctor served in Port Hueneme, California, advance base, port of embarkation 300 bed dispensary.

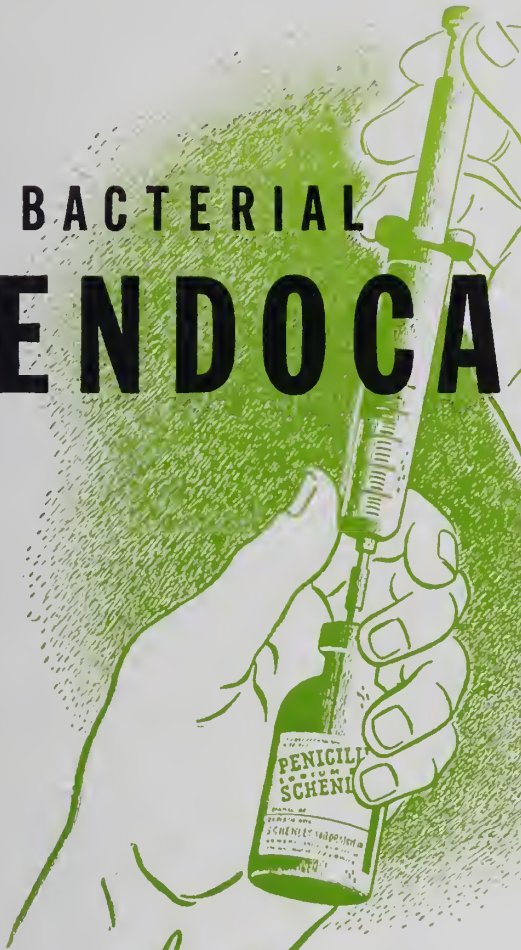
The doctor again went overseas in March, 1945, taking part in the Mindanao invasion, and serving at a dispensary in Ilollo, Panay, and with the Liaison Medical Office of the Army and Navy at Manilla.

He wears the following ribbons: European Theater of Operations with bronze star, South Pacific with star, American Theater, and Philippine Liberation with star.

Captain Irvin E. Gaynon, Milwaukee, is now on terminal leave from the Army, which he entered July 13, 1942. Captain Gaynon will be officially discharged August 6. While on active duty, the doctor was stationed at Camp Robinson, Little Rock, Arkansas; the 112th Station Hospital and the 263d Station Hospital, both in India; and Fort Sheridan, Illinois.

Captain Gaynon is entitled to wear the Asiatic–Pacific and American Theater ribbons.

BACTERIAL ENDOCARDITIS



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Final determination of cure depends upon long-term observation, but if the patient remains asymptomatic and bacteriologically free for a period of 4 weeks after cessation of penicillin therapy, the prognosis for complete cure is excellent. However, it must be remembered that valvular damage and renal lesions are not favorably influenced.

DAWSON, M. H., AND HUNTER, T. H.: *The Treatment of Subacute Bacterial Endocarditis with Penicillin: Results in Twenty Cases, J.A.M.A. 127:129 (Jan. 20) 1945*. . . FAVOUR, C. B.; JANEWAY, C. A.; GIBSON, J. G., II, AND LEVINE, S. A.: *Progress in the Treatment of Subacute Bacterial Endocarditis, New England J. Med. 234:71 (Jan. 17) 1946.*

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Commander James H. Goodlad, of Madison, who entered the Navy July 15, 1941, began his terminal leave February 14. Commander Goodlad was called into military service from Kansas City, where he had just started his practice. The doctor was stationed at San Diego, California, until Pearl Harbor, then transferred to the Marine Corps, and served four months on Guadalcanal. Wounded at Tarawa, he recuperated in a New Zealand hospital. For three months he was a patient at the Pearl Harbor Hospital and at a hospital in San Diego, where he also helped the other doctors. Then, after a period of work with the Milwaukee Recruiting and Induction group, he served in surgery at Great Lakes, Illinois, until his release.

Among the seven ribbons Commander Goodlad wears are: Pre-Pearl Harbor, Pacific Theater, and the Purple Heart. He also holds two Presidential Citations.

Lieutenant Lawrence W. Hargarten, Milwaukee doctor who entered the Navy in May, 1944, from internship at St. Joseph's Hospital in Milwaukee, received a discharge April 22. After training at Farragut Naval Station, Farragut, Idaho, Lieutenant Hargarten was transferred to the Naval Station, Seattle, Washington. From September, 1944, to February, 1946, he served on the USS General M. M. Patrick. Upon returning to this country, the doctor spent a month at Roosevelt Naval Base, San Pedro, California, before securing his release from active duty.

He is a wearer of the Asiatic–Pacific, Philippine Liberation, European–African Theater ribbons, and the American Area Campaign ribbon.

Upon completion of two and one-half years active duty, started in November, 1943, **Lieutenant Commander Frederick C. Heinan** of West Allis, received his discharge from the Navy April 20. Lieutenant Commander Heinan trained at Great Lakes, Illinois, and served at the Navy Recruiting Station in Chicago, until he was assigned eighteen months of duty aboard the USS Tate A.K.A. 70 in the Pacific. The doctor then served another period at Great Lakes before securing his discharge.

He wears the American Area, Philippine Liberation (with one star), and Asiatic–Pacific (with one star) Theater ribbons.

Lieutenant Commander J. Howard Johnson, Milwaukee, orthopedic surgeon, who began active duty with the Navy December 10, 1942, was discharged March 8. The doctor rendered military service at Naval hospitals in Bainbridge, Maryland, and Great Lakes, Illinois. In September, 1943, he was assigned duty at San Francisco, and in April, 1944, went to the Admiralty Islands, Base Hospital 15.

Over five years of active service with the Army came to an end for **Captain Earl T. Kendall** of Wauwatosa, when he was discharged April 1. Entering the Army in January, 1941, from residency at St. Mary's Hospital, Racine, the doctor served with the 135th Medical Regiment in the United States and in the Southwest Pacific, and at the Station Hospital, Fort Sill, Oklahoma.

Captain Kendall wears the Pre-Pearl Harbor, American Theater, and Southwest Pacific Theater ribbons, and has a star for the battle of New Guinea. He was awarded the Distinguished Unit Citation.

Lieutenant Commander Jack L. Kinsey of Milwaukee, who became a Navy physician in September, 1942, received a discharge April 29. The doctor was stationed at medical centers in Bethesda, Maryland; Great Lakes, Illinois; San Bruno, Oakland, San Francisco, and Mare Island, California. He wears the American Theater ribbon.

Major Robert W. Mann, Milwaukee, was discharged from the Army, February 2, after serving in this country and overseas since October 1, 1942. After a year at Halloran General Hospital, Staten Island, New York, Major Mann reported for duty with the 90th General Hospital in England and later in France. His service record shows duty with the following units: the 55th AAA Brigade in Holland and Belgium; the 108th Evacuation Hospital in Holland and Germany; and the 5th Auxiliary Surgical Group in Germany and France.

Major Mann wears the American Theater ribbon and the European Theater of Operations ribbon with stars for the battles of Northern France, Rhineland, and Central Germany.

Dr. Charles J. Newcomb, formerly of Milwaukee, who entered the service September 24, 1942, recently secured a discharge and has returned to civilian practice, opening an office with Dr. Howard C. James in Tucson, Arizona.

G. E. OOSTERHOUS

Captain George E. Oosterhous, former pediatrics specialist with the Dean Clinic, Madison, was discharged from the Army at Camp McCoy, Wisconsin, May 25, after thirty-eight months of service with the Medical Corps. Doctor Oosterhous, after training at the Medical Field Service School, Carlisle Barracks, Pennsylvania, served at the following Army posts: Air Force Technical Training School, Sioux Falls, South Dakota; Winter General Hospital, Topeka, Kansas; and Station Hospital, Camp McCoy. He also served in England.

The doctor returned to practice with the Dean Clinic July 1.

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Dr. L. Maramon Pippin, formerly of Boscobel, returned to the Pippin Clinic, Richland Center, following his discharge from the Army in April. He entered the Army January 14, 1944, and was stationed at camps in the country, among them Carlisle Barracks, Pennsylvania, and the Army center at Flintstone, North Carolina.

March 26, was the day **Captain Walter S. Polacheck** of Milwaukee received a discharge from the Army after serving since July, 1942. While in service the doctor was assigned duty in the Station Hospitals at Camp Crowder, Missouri, and Fort Snelling, Minnesota, and with the 116th General Hospital serving in the European Theater.

Captain Polacheck is entitled to wear the American Theater and European Theater of Operations ribbons.

Lieutenant Commander Rolf A. Quisling of Madison, has resumed his practice at the Quisling Clinic, Madison, following his recent release from the Navy, which he entered November 8, 1943. The doctor served eighteen months in the ear, nose, and throat departments at the U. S. Naval Air Technical Training Center, Memphis, Tennessee. He then was transferred to the Naval Receiving Hospital, San Francisco. Later, Doctor Quisling was assigned to the Naval Hospital, Mare Island, California, where he was chief of the ear, nose, throat, and nasal plastic surgery department.

Lieutenant Commander Maurice G. Rice, Stevens Point, was discharged from the Navy February 24. Upon entering the service December 7, 1942, the doctor was stationed at the Naval Hospital, Seattle, Washington, until he was assigned to duty on the USS Tippecanoe in April, 1943. Lieutenant Commander Rice returned to this country in December, 1944, and served at the Naval Hospital, Great Lakes, Illinois, until his discharge.

Upon completion of five years of active duty with the Army, **Lieutenant Colonel Leonard E. Rothman**, Milwaukee physician, secured a discharge Jan. 14. Record of the doctor's Army service, started December 30, 1940, shows he served with the following groups: 1st Armored Division, Fort Knox, Kentucky; 4th Armored Division, Pine Camp, New York; 6th Armored Division, Camp Chaffee, Arkansas, and overseas; 11th Evacuation Hospital, Germany; and 96th Evacuation Hospital, Germany.

Lieutenant Colonel Rothman wears the Pre-Pearl Harbor ribbon and the ribbon of the European Theater of Operations, with battle stars for Normandy, France, Ardennes, Germany, and Central Europe. He was awarded the Bronze Star, the Silver Star, and the Legion of Merit Medal.

Wausau physician, **Major Richard C. Shannon**, was discharged from the Army April 14. He entered service August 1, 1942, from internship at the Milwaukee County Hospital. After training at Carlisle Barracks, Pennsylvania, Major Shannon served with the 56th Armored Engineers Battalion at Camp Polk, Louisiana, Camp Barkeley, Texas, and Camp Ibis and Camp Cooke, California. In March, 1945, he transferred to Headquarters, 70th Medical Battalion, and was stationed at Fort Ord and Camp Stoneman, California, and at Finchhafen, New Guinea. He became commanding officer of the 412th Medical Call Company in June, 1945, at Finchhafen; Los Negros, Admiralty Islands; and Leyte and Mindoro, Philippine Islands. Later he was with the 9th Corps Surgery Office at Leyte, until sent to replacement depots and eventually back to this country November 25, 1945.

Major Shannon wears the Asiatic-Pacific Theater ribbon with three bronze stars and a bronze arrow head, the American Theater ribbon, and the Philippine Liberation ribbon with two bronze stars. He was awarded the Combat Medical Badge and the Bronze Star Medal.

Lieutenant Colonel Joseph R. Stone of Milwaukee, who entered the Army January 19, 1941, received a discharge November 15, 1945. Stationed first at Brooks General Hospital, Fort Sam Houston, Texas, Lieutenant Colonel Stone transferred in February of 1941 to the Station Hospital, Camp Wolters, Texas. January 1, 1944, he left for duty in the Southwest Pacific with the 35th General Hospital, returning to this country October 6, 1945.

He is a wearer of the Asiatic-Pacific Theater, Philippine Liberation, Pre-Pearl Harbor, and American Defense ribbons with bronze stars for the New Guinea and Philippine campaigns.

Milwaukee practitioner, **Captain Samuel J. Sweet**, has returned to civilian life following his discharge from the Army, March 13. Lawson General Hospital, Atlanta, Georgia, was Captain Sweet's first post after entering the Army in March, 1944. He then served at the Station Hospital, Camp Van Dorn, Mississippi, and with the 238th General Hospital at Camp Barkeley, Texas, going overseas with the latter to serve in Mirecourt, France, and Arlon, Belgium. In September, 1945, the doctor transferred to the 85th Evacuation Hospital, Ellwangen, Germany, serving there until two months before his discharge.

Captain Sweet wears the European-African-Middle East Theater ribbon with two bronze battle stars.

Army Medical Corps man, **Captain John N. Thanos** of Milwaukee, received his discharge February 5, at the completion of five years of active duty. Entering military service January 13, 1941, Captain Thanos was sent immediately to Australia with the 135th Medical Regiment. Three years later he was assigned to Base Section 3, Base Surgeon's Office, Brisbane, Australia, for four months duty until transferred to the 91st Station Hospital for service

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at Brisbane, and Leyte, Philippine Islands. In November of 1944, the doctor was assigned to the 133d General Hospital also on Leyte, serving there until April, 1945.

A wearer of the American Defense, Asiatic-Pacific Theater (with four stars), and Philippine Liberation (with one star) ribbons, Captain Thanos was awarded the Bronze Star Medal.

Lieutenant Anthony J. Verdone of Milwaukee, who entered the Navy February 8, 1944, received a discharge April 30. After a few weeks at the Induction Center, Great Lakes, Illinois, Lieutenant Verdone was stationed at the following centers: San Bruno, California, Naval Training Station; Bremerton, Washington, Navy Yard Dispensary; on board the USS Ramapo; and again at Great Lakes. He wears the American and Asiatic-Pacific Theater ribbons.

Former Milwaukee physician, **Captain Theodore D. Watry**, who entered the Army October 14, 1940, received a discharge March 1. He is now practicing at Dousman, Wisconsin. Captain Watry served in the United States for over three years, and spent two years and two months in foreign service in Africa, Sicily, and Italy.

He wears the American Defense ribbon and the European-African-Middle East Theater ribbon with four bronze stars.

A resident physician at Wisconsin General Hospital, Madison, until he entered the Navy in January, 1944, **Lieutenant John M. Wilson** was discharged June 13, and has started a practice at Johnson City, Tennessee. While in the Navy, Lieutenant Wilson was stationed at the Naval Hospital, Chelsea, Massachusetts; on board the USS Eldorado (AGC–11); and at the Naval Hospital, Bethesda, Maryland. He wears the American, Asiatic-Pacific and Philippine Theater ribbons with battle stars for Iwo Jima and Okinawa.

Three years and three months of active duty with the Navy terminated with a discharge March 5, for **Lieutenant Commander Carlton Wirthwein**, Milwaukee physician. After entering military service December 26, 1942, the doctor was assigned duty at the Naval Hospital, Farragut, Idaho. In February, 1943, he was sent to the South Pacific, serving with the 1st M.A.C., and from February, 1944, to December, 1944, with the 1st Marine Division. Service at the United States Naval Dispensary, Washington, D. C. until discharge, followed his return to this country.

Lieutenant Commander Wirthwein wears the American and Asiatic-Pacific Theater ribbons.

Racine physician, **Lieutenant Robert S. Wright**, has returned to civilian life following two years and eight months in the Navy. He entered the service August 16, 1943, and was discharged April 30, 1946. Lieutenant Wright's military record shows he served at the following stations: Naval Hospital, Great Lakes, Illinois; Naval Ammunition Depot, Crane, Indiana; School of Aviation Medicine, Pensacola, Florida; Naval Air Station, Key West, Florida; on board the USS Tangier in Philippine waters; Patrol Bombing Squadron 117, Mindoro, Philippine Islands; and Naval Air Base, Tinian, Marianne Islands.

A new veterans organization entitled, "The Medical Veterans of World War I and II of Milwaukee County," has been formed, in which all medical officers of both World Wars are eligible for membership.

For further information about the group consult the article in the Medical Forum section of this issue.

Recent Releases From Service*

Physician and Location	Date Discharged
Adrians, W. A., Hortonville	October, 1945
Benson, R. R., Madison	June, 1946
Bleckwenn, W. J., Madison	May, 1946
Boren, J. W., Jr., Marinette	March, 1946
Champney, R. D., Milwaukee	February, 1946
Christiansen, W. H., Milwaukee	February, 1946
Cleveland, David, Milwaukee	June, 1946
Cook, J. C., Racine	June, 1946
Correll, H. L., Milwaukee	February, 1946
Creswell, C. M., Kenosha	March, 1946
Daniels, E. R., Wauwatosa	February, 1946
Donkle, M. J., Oshkosh	December, 1945
Drozewski, M. F., Milwaukee	January, 1946
Eck, G. E., Lake Mills	March, 1946
Feiman, L. H., Milwaukee	February, 1946
Feurig, J. S., Green Bay	January, 1946
Fifrick, L. L., Wauwatosa	May, 1946
Hanson, O. H., Fort Atkinson	March, 1946
Haushalter, L. E., Milwaukee	January, 1946
Jorgensen, P. B., Mosinee	February, 1946
Kendall, E. T., Wauwatosa	April, 1946
Klotz, A. P., Shawano	February, 1946
Kreher, J. E., Mondovi	July, 1946
Kretlow, F. A., Milwaukee	January, 1946
Little, W. W., Washington Island	December, 1946
Mann, R. W., Milwaukee	February, 1946
Martens, E. W., Milwaukee	February, 1946
McCabe, J. O., Milwaukee	April, 1946
Monroe, M. E., Hartford	March, 1946
Rogers, A. F., Milwaukee	January, 1946
Ruskin, B. A., Wauwatosa	May, 1946
Schneeberger, L. J., Milwaukee	February, 1946

* Members of the State Society listed in boldface.

(Continued on page 710)

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and William . . .

and James . . .

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Schoenecker, E. A., Lake Mills	May, 1946
Settlage, H. A., Lone Rock	January, 1946
Silbar, S. J., Milwaukee	December, 1945
Sowka, P. N., Stevens Point	April, 1946
Thompson, R. D., Milwaukee	February, 1946
Troup, W. J., Green Bay	May, 1946
Wangeman, C. P., Madison	March, 1946
Wasserman, S. E., Milwaukee	June, 1946
Watry, T. D., Dousman	March, 1946
Weisfeldt, S. C., Milwaukee	February, 1946
Wilson, J. M., Madison	June, 1946
Wishart, J. H., Eau Claire	June, 1946

VETERAN PHYSICIANS' EXCHANGE

This page will be devoted to a classified section, open without charge to: (a) veteran members desiring location and (b) other members having professional openings suitable for men returning from military service.

LOCATIONS WANTED

LOCATION WANTED: General surgeon, 36, who has completed first part of American Board examinations, served in charge of general surgery section in general hospital while in the Army, and is licensed in Wisconsin and Minnesota, desires clinic connection in this region. Will also consider association with internist or small group on a share office basis. Available about August 1. Address No. 129 in care of the Journal.

LOCATION WANTED by young, married, Protestant doctor of Norwegian descent. Has done general practice in small country town for past 8 years. Two years Army service with honorable discharge. Graduate of a class A medical school and at present practicing at location occupied prior to Army service. Desires association with busy doctor doing own surgery in small city with hospital facilities. References gladly exchanged. Personal interview can be arranged. Address No. 130 in care of the Journal.

ASSOCIATION WANTED: Army veteran, age 34, with 5½ years of surgical training, desires association with a surgeon, or a position as surgeon for a group, clinic, or community. Excellent references. Address No. 131 in care of the Journal.

LOCATION WANTED as business manager of hospital, clinic, or sanitarium. Please note Physicians' Exchange item No. 51 on page 730 of this issue.

WANTED: Location or association with older physician or group in Middlewest community of 5,000–50,000. I am 33, gentile, married, graduate of Class A school, with 2½ years surgical residency, and 2½ years surgical experience in Army hospitals. Letters of reference on request. Consider partnership and prefer general practice with opportunity to do surgery. Permanent location desirable. Available about July 1. Can arrange personal interview. Address No. 126 in care of the Journal.

LOCATION WANTED: I would like to locate in a small or medium-sized town. Have had 3 years' training at Milwaukee County General Hospital and 4 years of general practice in Milwaukee. Address No. 128 in care of the Journal.

ASSISTANCE WANTED

WANTED: Good opportunity for permanent position in general practice open now in a Southern Wisconsin Clinic. The work involves some surgery, obstetrics, general and industrial medicine. Percentage basis considered. Address No. 105 in care of the Journal.

LOCUM TENENS WANTED: A capable physician desires locum tenens for a short or long period. Will not compete afterwards. Licensed in Wisconsin. References furnished. Address No. 125 in care of the Journal.

ASSISTANT WANTED: Young man well trained in obstetrics and surgery for assistantship with busy general practitioner located in the heart of Milwaukee. Office well equipped and staffed. Association on increasing percentage, leading to partnership. Address No. 127 in care of the Journal.

ASSOCIATE DESIRED: To do internal medicine and pediatrics. Also required to assist in major surgery. Excellent opportunity in a good community which has a well-equipped 60-bed hospital. Applicants must have had postgraduate training in internal medicine or pediatrics. Address No. 115 in care of the Journal.

WANTED: Assistant interested in general practice and future association as partner. $300 per month and commission to start. Prefer single, Protestant, young returning serviceman or recent graduate. Address No. 123 in care of the Journal.

VETERAN PHYSICIANS: This is a strategic time to enter public health. State Board of Health has 2 openings for physicians with executive ability as directors of the tuberculosis and venereal disease divisions. Salary $4,800 to $5,400 plus necessary traveling expenses, Madison headquarters. 5 district health officers also needed. If you were under 40 when entering the armed services and can otherwise qualify, write Dr. Carl N. Neupert, State Health Officer, Madison 2, Wisconsin.

WANTED: Staff physician at sanatorium approved for tuberculosis residency. Beginning salary $250–$300, less modest maintenance deduction. One position open July 1, another probable the last of March. Wisconsin licensure required. Person must have good professional and personal qualities. Write Superintendent, Wisconsin State Sanatorium, Statesan, Wisconsin.

For additional classified advertisements, see the Physicians' Exchange, page 730

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Society Proceedings

Eau Claire—Dunn—Pepin

Meeting at the Elks Club in Eau Claire, May 27, members of the Eau Claire–Dunn–Pepin County Medical Society heard a talk entitled "Inter Vertebral Discs," by *Dr. A. C. Stirling*. Dr. D. L. Dickerson presented a speech on "Goiter." Both doctors are with the Jackson Clinic in Madison.

Fond du Lac

Members of the Fond du Lac County Medical Society entertained their wives at a dinner meeting May 25, at the Heidel House, Green Lake. *Dr. P. G. McCabe*, president of the society, presided. The program, arranged by *Dr. J. M. Johnson* of Ripon, was provided by students of Ripon College comprising the cast of a musical comedy given recently at Ripon.

Jefferson

The Jefferson County Medical Society members met May 16 at the Washington Hotel in Watertown. They voted to have no meetings during the months of June, July, and August.

Trempealeau—Jackson—Buffalo

Presenting an illustrated lecture on fractures of the upper and lower extremeties, Dr. William H. Bickel of the Orthopedic Department of Mayo Clinic, Rochester, Minnesota, appeared before members of the Trempealeau–Jackson–Buffalo County Medical Society at their May 16 meeting in the MacCornack Clinic, Whitehall.

The June meeting of the society was postponed so as not to conflict with the seventh councilor district meeting in La Crosse.

Vernon

Following a dinner at the Oriole Cafe, Viroqua, June 13, provided by the Viroqua Hospital Corporation, the Vernon County Medical Society elected new officers: *Drs. A. E. Kuehn*, Viroqua, president; *Halbert Gullbrandsen*, Viroqua, vice-president; *C. M. Strand*, Westby, secretary-treasurer; *R. S. Hirsch*, Viroqua, delegate; and *F. F. Gollin*, La Farge, alternate.

Waupaca

New officers of the Waupaca County Medical Society, elected at a recent meeting are: *Drs. G. P. Dernbach*, New London, president; *C. P. Arnoldussen*, Fremont, vice-president; and *J. W. Monsted*, New London, secretary-treasurer.

Wood

At the Wood County Medical Society meeting, May 23, held at the Witter Hotel in Wisconsin Rapids, three doctors provided the program for the evening. "A Case of Tetanus," presented by *Dr. Leland Pomainville* of Wisconsin Rapids, was followed by a speech entitled, "Advances in Urology in General Practice," given by *Dr. H. H. Christensen* of Wausau. *Dr. J. J. Smullen*, Wisconsin Rapids, talked on "Four Cases of Acute Catarrhal Jaundice in One Family."

Radiologic Section of the State Medical Society

Chairmaned by *Dr. Lawrence V. Littig* of Madison, the Radiologic Section of the State Medical Society held meetings May 17 and 18, at Devi-Bara resort on Devil's Lake, Baraboo. Scientific sessions convened and the election of officers was conducted. The new officers are as follows: *Drs. E. A. Pohle*, Madison, chairman; *S. R. Beatty*, Neenah, vice-chairman; *I. I. Cowan*, Milwaukee, secretary-treasurer; *L. V. Littig*, Madison, delegate; and *R. F. Wilson*, Beloit, alternate.

American Congress of Physical Medicine

The twenty-fourth annual scientific and clinical session of the American Congress of Physical Medicine will meet September 4, through September 7, at the Hotel Pennsylvania, New York City. In addition to the scientific gatherings, instruction courses open to physicians and to therapists registered with the American Registry of Physical Therapy Technicians, will be held September 4, 5, and 6.

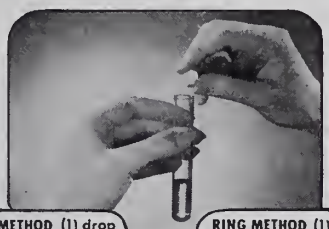
Milwaukee Oto-Ophthalmic Society

At its annual meeting, May 28, in the Milwaukee Athletic Club, the Milwaukee Oto-Ophthalmic Society nominated the following officers for the ensuing year: *Drs. Meyer Fox*, president; *Frank G. Treskow*, vice-president; and *Earl W. Mertens*, secretary-treasurer. The business meeting preceded a talk by *Dr. Rudolf Teschan* entitled, "A Bit of Legerdemain."

Tri-County Medical Society

Dr. John F. Bennett of Burlington, talking on "Treatment of Respiratory Infections," was the first of a number of speakers who addressed the Tri-County Medical Society June 19, at Big Foot Country Club, Fontana-on-Geneva Lake. Others who appeared on the full day program were: *Dr. R. P. Sproule*, Milwaukee—"Acute Eye Infections;" *Dr. H. W. Wirka*, Madison—"Orthopedic Problems in General Practice;" *Dr. H. W. Shutter*, Milwaukee—"Pre- and Post-Natal Management;" and *Dr. W. M. Kearns*, Milwaukee—"Recent Advances in Urology."

After an afternoon planned for recreational activities, the society members heard an address by



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Mr. C. H. Crownhart about the activities of the State Medical Society, of which he is secretary. Also at the dinner meeting *Dr. H. Kent Tenney* of Madison, discussed the American Academy of Pediatrics, Wisconsin Study of Child Health Services, of which he is state chairman.

Wisconsin Society of Obstetrics and Gynecology

Dr. Joseph M. Freeman of Wausau, was elected president of the Wisconsin Society of Obstetrics and Gynecology at the society's spring meeting May 24, in Wausau. *Dr. Woodruff Smith*, Ladysmith, was re-elected vice-president, and *Dr. L. T. Servis*, Milwaukee, was chosen secretary-treasurer. The fall session of the society is planned for November, in Madison.

Wisconsin Orthopedic Society

Dr. Chester C. Schneider of Milwaukee, was recently elected president of the Wisconsin Orthopedic Society. Secretary-treasurer of the organization is now *Dr. Albert C. Schmidt*, also of Milwaukee.

Milwaukee Neuro-Psychiatric Society

Meeting at the Milwaukee Athletic Club May 23, members of the Milwaukee Neuro-Psychiatric Society heard *Dr. Harry P. Maxwell* present a speech entitled, "The Incidence of Interhemispheric Extension of Glioblastoma Multiforme Through the Corpus Callosum."

Sheboygan

The St. Nicholas Hospital in Sheboygan was the scene of the June 13 meeting of the Sheboygan County Medical Society. The business of the meeting consisted of a motion carried to send cards to the members requesting volunteers for Cancer Detection Center work. Communication regarding Child Guidance, requesting that the society go on record as approving it and desiring it continued, was read and approved by the society.

Walworth

The Walworth County Medical Society was host to the Tri-County Medical Society and auxiliary at a meeting in the Big Foot Country Club at Fontana, June 19. The all-day session was arranged by *Dr. E. D. Hudson* of Lake Geneva, president of the Walworth County organization. Mrs. Joseph Rawlins of Elkhorn, is president of the Medical Society auxiliary which entertained the ladies of the Tri-County group.

AND ABOUT THE THIRD DISTRICT:

"With a marked concentration of physicians in the Third Councilor District, the *Journal* is assembling all news items pertaining to activities of physicians in Dane, Rock, Green, Columbia, Sauk, Marquette and Adams Counties and presents them together. The *Journal* urges county secretaries to send personal items of interest. Such notices should reach our office by or before the fifteenth of each month before publication."

—EDITOR'S NOTE

SOCIETY PROCEEDING

Dane

Members of the Dane County Medical Society gathered at Mendota Hospital, June 11, for a softball game and dinner, an annual affair. An inspection tour of the hospital was conducted during this last meeting of the season. *Drs. A. C. Atwood* and *Louis Fauerbach* of Madison were in charge of the refreshments served during the afternoon, and the dinner was arranged by *Dr. Morton Green* of Mendota.

COUNCILOR DISTRICT NEWS

The Wisconsin Alumni Research Foundation, Madison, on June 1, appointed Dr. Christian P. Segard of Leonia, New Jersey, as medical director of the Foundation.

Dr. Henry V. Bancroft, Blue Mounds physician, was elected to honorary membership in the State Medical Society at the Council meeting of the Society May 26. In view of his sixty years of practice in his community, where he has served "in an honorable and intelligent manner," he was recommended by the Board of Trustees of the Dane County Medical Society.

Doctor Bancroft, born February 14, 1860, and graduated from Rush Medical College, Chicago, in 1885, was licensed to practice in Wisconsin in 1899. The doctor, a widower with six children, is serving as village health officer.

—△—

The fourth annual A. C. Helmholz Lecture of the University of Wisconsin Medical Society was presented June 20, by Dr. Thomas Francis Jr., pro-

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fessor of epidemiology of the School of Public Health, University of Michigan, on the subject, "The Conquest of Influenza." The auditorium of the Service Memorial Building, Madison, was the scene of the lecture.

SOCIETY RECORDS

New Members

H. V. Malin, Elkhorn.

E. Frank Castaldo, Laona.

A. L. Babbitz, 606 West Wisconsin Avenue, Milwaukee 3.

W. E. Kiley, 2020 East North Avenue, Milwaukee.

T. E. Kendall, 8721 West North Avenue, Milwaukee.

O. C. Berg, 238 West Wisconsin Avenue, Milwaukee 3.

E. G. Collins, 6124 West National Avenue, Milwaukee.

R. M. Simpson, 632 North Eighth Street, Sheboygan.

L. J. Schwade, 536 West Wisconsin Avenue, Milwaukee 3.

R. F. Swanson, Grafton.

G. S. Cassels, Port Washington.

R. C. Mathewson, 1521 North Prospect Avenue, Milwaukee.

T. S. Buskiewicz, 529 North Thirteenth Street, Milwaukee.

J. W. Easton, 301 Board of Trade Building, Superior.

L. E. Friedrich, Brownsville.

G. K. Kambara, 224 West Washington Avenue, Madison 3.

L. J. Olson, 419 River Avenue, Spooner.

K. L. German, 219 South Barstow, Eau Claire.

M. A. Myers, 217 North Orchard Street, Madison.

R. C. Beardsley, 9 West Main Street, Madison 3.

P. M. Cunningham, 224 North Oneida Street, Appleton.

Changes in Address

H. V. Crum, Port Washington, to Rushville, Neb.

R. S. Rodgers, Chippewa Falls, to 40 Littlefield Road, Newton Center, Massachusetts.

L. G. Culver, Eau Claire, to Lowry Medical Arts Building, St. Paul, Minnesota.

L. G. Nezworski, Superior, to Middle River Sanatorium, Hawthorne.

T. D. Watry, Milwaukee, to Dousman.

C. M. Creswell, Pasadena, California, to 625 Fifty-seventh Street, Kenosha.

C. J. Kocovsky, Milwaukee, to 7200 West North Avenue, Wauwatosa.

H. H. Hull, Brandon, to 401½ East Main Street, Waupun.

R. G. Mayer, Eau Claire, to 113 East Fifth Street, Kaukauna.

J. R. Peterson, Milwaukee, to 308 Fifteenth, S. W., Rochester, Minnesota.

J. D. Walsh, Chicago, to 161 West Wisconsin Avenue, Milwaukee 2.

A. A. Unger, Milwaukee, to 10922 Lindblade Street, Culver City, California.

BIRTH

A son to Dr. and Mrs. Kenneth A. Seifert, West Allis, on June 25.

DEATHS

Dr. Charles D. Packard, 79, of Rhinelander, who had practiced medicine in that city for fifty years, died at his home, Saturday, June 1. He had been in failing health for several years and retired from practice in 1941.

Doctor Packard attended Rush Medical College and graduated from the University of Illinois College of Medicine in Chicago with the class of 1893. In the same year he started practice in Rhinelander in association with the late Dr. A. D. Daniels. Ten years later Doctor Packard established his own office.

The doctor was a former member of the Oneida–Vilas County Medical Society and the State Medical Society. Active in the development of St. Mary's Hospital, he served as city health officer for some years.

Survivors include the doctor's wife and a son, Dr. John S. Packard.

Dr. Carl E. Stubenvoll, 77, pioneer Shawano physician and surgeon, died at a local hospital Tuesday, June 11, following a year's illness.

Born in Baden, Germany, and graduated from the University of Heidelberg Medical School in 1892, the doctor came to this country fifty-four years ago to begin practice in Racine. Later he moved to Tigerton, where he resided for nine years.

Doctor Stubenvoll was in charge of the German–American Hospital, Oshkosh, before he became one of Shawano's first surgeons and founder of the city's first hospital twenty-five years ago. He also served on the staff of St. Mary's Hospital in Green Bay for many years.

A member of the Shawano County Medical Society and the State Medical Society, the doctor was a Fellow in the American Medical Association.

Doctor Stubenvoll is survived by two sons and two daughters.

Dr. Frederick M. Schmidt of Eagle, died at a Waukesha hospital Monday, June 10. He was 58 years old.

Doctor Schmidt, a 1911 graduate of the Wisconsin College of Physicians and Surgeons in Milwaukee, practiced for thirty-five years in Eagle and served on the Waukesha Memorial Hospital staff.

A member of the Waukesha County Medical Society and the State Medical Society.

Doctor Schmidt is survived by his wife and one son.

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News Items and Personals

Dr. John William Smith of Milwaukee was appointed in April by Mayor John L. Bohn of that city, as trustee to the Milwaukee Public Library Board for one year to fill the unexpired term of the late Mr. Archie Tegtmeyer, who was outstanding in public welfare work.

Doctor Smith has served on the Board of Medical Examiners for four years.

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Four Manitowoc physicians returned to private practice after serving in the Medical Corps of the armed services, were honored at a testimonial dinner May 15, given by the Sisters at the Holy Family Hospital, Manitowoc, for all staff doctors. *Drs. R. W. Hammond, L. W. Gregory, R. S. Simenson,* and *N. C. Erdmann,* the guests of honor, were welcomed with an address by *Dr. F. E. Turgasen* of Manitowoc. Doctor Erdmann responded for the returned veterans, and *Dr. Erwin C. Cary* of Reedsville, chief of staff, served as toastmaster.

—△—

"Whatever goes on in the world anywhere is our business," declared *Dr. John S. Wier* of Fond du Lac, who served as a Colonel in the Army Medical Corps overseas during World War II, when he addressed a meeting of the Beaver Dam Kiwanis Club in May. He spoke of his experiences in the European Theater.

—△—

Dr. W. D. James of Oconomowoc, a Major in World War II, spoke on "Medical Service with the Field Troops," at a meeting of the Edwin L. Jones Post of the American Legion, held in the Armory, Oconomowoc, June 20.

—△—

Dr. Earl D. McConnell of the McConnell & McGreane Hospital, Darlington, spoke before the Darlington Kiwanis Club June 17, stating his views and opinions in regard to the establishment of a new hospital in the community. The doctor advocated a new building to be attached to the present hospital building to accommodate thirty-three patients.

—△—

Dr. Michael Kasak of Wauwatosa, medical director of the Milwaukee County Hospital for Mental Diseases, was promoted to the rank of professor and director of the Division of Psychiatry at the Marquette University School of Medicine recently. The doctor has been associate clinical professor and in charge of psychiatry in the senior class since 1931, and in 1944 also became acting director of the Division of Psychiatry.

—△—

Meeting in Chicago, May 5 through May 11, the American Board of Obstetrics and Gynecology, Incorporated, certified one hundred forty-one candidates. A number of changes in Board regulations and requirements were put into effect at the meeting.

November 1, 1946, has been set as the closing date for receiving applications for the next written examinations, to be held at 2 p. m., Friday, February 7, 1947, in various cities of the United States and Canada.

—△—

Former patients and employees of the Riverview Sanatorium, Appleton, honored *Dr. C. D. Boyd* of Kaukauna, who resigned April 8, as superintendent and medical director of the sanatorium, with a special dinner June 6, at the Elks Club in Appleton. The doctor has served the sanatorium that he helped organize for thirty-two years, and has long rendered service to the townspeople of Kaukauna.

—△—

Dr. G. R. Duer of Marinette spoke before the Marinette Kiwanis Club, June 17, at its regular weekly meeting in the Hotel Marinette, on developments in medicine and surgery in the past one hundred years. He paid tribute to the late Doctor Redelings for his work in filtering Marinette's water supply and the purification of its milk supply.

—△—

The educational program at the Wood Hospital, Veterans Administration Center, Wood, providing refresher courses for all physicians practicing in the city, county, and state, has the following teaching schedule weekly at present:

Monday

9:00–10:00—Dr. J. Hirschboeck, Hematology
11:00–12:00—Medical Service Lectures

Tuesday

9:00–10:00—Dr. J. P. Conway, Tropical Diseases
10:00–11:00—Dr. H. Correll, Cardiovascular

Wednesday

10:00–11:00—Dr. Silas Evans, Chest Diseases
11:00–12:00—Medical Service Conference of Journal Club, Dr. M. Hardgrove, chairman
1:00–2:00—Dr. Liberman, Dr. Primakow, N. P.

Thursday

9:00–10:00—Dr. Markson, Office
10:00–11:00—Dr. Lindert, G. I., Annex II

Saturday

10:00–11:00—Dr. B. Peters, Metabolism
11:00–12:00—Clinical Pathological Conference and Staff Meeting

Doctors are welcome to attend the meetings, conducted formally or as discussions, as well as to make the daily ward rounds.

Florida State Board of Health findings[1] of rickets in well over 50% of 2,000 school children substantiate California reports[2] on the antirachitic unreliability of sunshine. Logic suggests supplemental vitamins the year 'round, as long as growth persists. Upjohn vitamins provide a steadfast source of potent, natural vitamin D in convenient, well tolerated form.

1. Florida Health Notes 37, May, 1945.
2. Am. J. Dis. Child. 54:1227, 1937.

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With the subject, "Inhalation of Carbon Dioxide for the Management of Cough," *Dr. Andrew L. Banyai* of Milwaukee, spoke before the June 28 afternoon scientific session at the Twelfth Annual Meeting of the American College of Chest Physicians, held in San Francisco, June 27–30. Doctor Banyai, chairman of the college's Council on European Affairs, served as a co-chairman of the June 27 dinner meeting, and participated in the June 28 Forum as chairman of the Committee on State Laws for Tuberculosis.

—△—

Citizens of Denmark and Cooperstown, Wisconsin, and surrounding areas gathered June 4 to honor *Dr. W. H. Vosburgh*, 75, of Cooperstown, for his untiring service as a physician in the two communities for fifty years. More than 700 friends of the doctor, many of whom were brought into the world by the veteran practitioner, attended the public reception at the Denmark Pavilion, following a dinner at which Doctor and Mrs. Vosburgh were guests of the Denmark Business Men's Club.

"Doctor Vosburgh represents the part of the medical profession called the general practitioner . . . who does 90 per cent of all the medical work," declared *Dr. P. R. Minahan*, of Green Bay, president of the State Medical Society, speaking at the reception. *Dr. F. J. Gosin* of Green Bay, who represented the Brown–Kewaunee–Door County Medical Society, said, "The integrity and honesty of this man set a mark for the rest of us in his profession and for the people in civil life as well."

Attorney Cletus Chadek of Green Bay, the principal speaker, reviewed briefly Doctor Vosburgh's life, Mayor Edward Deitiker of Denmark presented the doctor with a watch on behalf of the townspeople, and Doctor Vosburgh gave a talk thanking his friends for the honor.

Born in Black Earth August 21, 1870, and graduated from the University of Illinois College of Medicine, Chicago, in 1896, Doctor Vosburgh interned at Cook County Hospital in Chicago, and then hung out his shingle in Cooperstown. Later, he opened another office in Denmark. He still maintains both offices. The doctor does not plan to retire but will take things easier now as he has given up obstetrics after delivering about 5,000 babies.

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Mrs. P. B. Blanchard, Cedarburg

Organization—
Mrs. C. N. Neupert, Madison

MRS. E. S. SCHMIDT

State Chairman of Legislation, Mrs. Schmidt has also served as past-president of the Auxiliary; on the Board of Education of Green Bay; as past-president and Board of Directors member of the Brown County Council of Social Agencies; trustee on local Community Chest Board; and as past-president of the Wisconsin Council of Catholic Women.

Since the State Legislature is not in session this year, efforts of the Chairman of Legislation were directed to a consideration of medical bills before Congress.

Appreciating the necessity of informing ourselves about the hazards of current medical legislation before discussing them with the laity, study groups were organized in several counties.

Intensive consideration was given to the Wagner-Murray-Dingell bill, the Pepper bill, the Hospital Survey and Construction bill, and plans for Voluntary Prepayment of Medical Care.

These group meetings were followed by an Auxiliary meeting open to guests interested in a summary and also a question and answer discussion of the bills studied.

Attention was directed to a study of bills slated to come up in the next legislative session, viz. The necessity of redistricting the health areas of the state and bills planning adequate care for the chronically ill and the aged.

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Auxiliary Proceedings

Douglas

The Auxiliary to the Douglas County Medical Society met in the Wedgewood room of the Androy Hotel, Superior, the evening of June 5. The program for the evening included vocal solos by Miss Clarice Decker accompanied by Miss Alice Austin. Feature of the evening was an address by Miss Gail Nelson on "Economy in Politics as an Influence to Peace." Her address recently won first place in a Rotarian contest.

Fond du Lac

The members of the Fond du Lac Auxiliary met at the home of Mrs. H. C. Werner, Fond du Lac, for tea on the afternoon of June 13. Mmes. L. A. Hoffmann, immediate past-president and J. J. Rehorst presided. Assisting hostesses were Mmes. A. M. Hutter, J. S. Wier, and E. V. Smith, Jr.

The following officers were elected: Mrs. Rehorst, president; Mrs. E. H. Pawsat, president-elect; Mrs. Smith, secretary; Mrs. R. L. Waffle, treasurer. Delegates to the state convention are Mmes. Hoffmann, Rehorst, and Pawsat. Alternate delegates are: Mmes. Smith and Waffle.

The new president announced committee chairmen for the coming year as follows: Mrs. J. S. Huebner, program; Mrs. Pawsat, social; Mrs. D. J. Twohig, philanthropic; Mrs. J. E. Twohig, public relations; Mrs. J. P. Connell and Mrs. W. C. Wojta, cancer control; Mrs. Smith, press and publicity; Mrs. T. A. Hardgrove, history and archives; Mrs. P. G. McCabe, hygeia, and Mrs. Hutter, bulletin.

Mrs. Huebner discussed the value of study groups and the auxiliary plans to continue its cancer control program during the summer months.

La Crosse

Mrs. Arthur J. McCarey, Green Bay, State President of the Woman's Auxiliary, was guest of honor and speaker at the meeting of the La Crosse County Society which was held at the home of Mrs. E. S. Carlsson, La Crosse, the afternoon of May 15. Assisting hostesses were Mmes. John Harman, George D. Reay, and Paul Anderson.

Pointing out that at the December meeting of the House of Delegates of the American Medical Association a resolution was passed asking the Auxiliary "to use every avenue possible to bring to the public knowledge concerning the hazards of current medical legislation," Mrs. McCarey urged the members to keep informed on the issues of political medicine. She further suggested that programs could be arranged, to which the public could be invited, for featured speakers to discuss government sponsored medical care plans.

Officers elected for the coming year are: Mrs. Joseph Richter, Chaseburg, president; Mrs. George B. Rideout, president-elect; Mrs. Paul Anderson, secretary; Mrs. D. M. Daley, treasurer.

Milwaukee

The final meeting of the year was held on May 10 at the Hotel Schroeder. Following luncheon, Mrs. James Johnson, Wauwatosa, spoke on and demonstrated "Flower Arrangements for the Home."

At the business meeting Mrs. Donald D. Frawley, recording secretary, read the minutes of the annual business meeting held in May of the preceding year; Mrs. William C. Liefert, State Convention Chairman, discussed the Convention plans and Mrs. Merle Q. Howard, general chairman for the Centennial Hall of Health, reported on the Auxiliary's part in this achievement.

An innovation was the presenting of the Annual Report on pamphlet form. The brochure replaced the customary oral reports which saved time at the annual meeting, preserved the information for future reference and made it available to those who were absent. Brief resumés of the duties of officers and committees and recommendations for succeeding groups were also included. Mrs. John D. Owen, treasurer, edited the bulletin. More than 100 women, over a fourth of the membership, participated actively in the work of the organization for 1945–46.

With Mrs. Eben J. Carey acting as parliamentarian, a unanimous ballot was cast for the following officers for the coming year: President-elect, Mrs. William H. Studley; Vice-President, Mrs. Edwin P. Bickler; Corresponding Secretary, Mrs. Bernard P. Churchill; Recording Secretary, Mrs. Milton G. Klumb; Treasurer, Mrs. Sidney J. Silbar. Board members elected to serve two years are: Mmes. N. Warren Bourne, Cecil B. Hake, and Joseph P. Wild.

Mrs. Merle Q. Howard was inducted into office as the new president after Mrs. Herman Heise, retiring president, was presented with her gavel.

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Outagamie

The Outagamie County Auxiliary met at the home of Mrs. Milo E. Swanton, Appleton for supper May 16. Assisting hostesses were Mmes. F. J. Huberty, J. W. Laird, and J. J. Young. A business meeting followed the supper.

Waukesha

The Woman's Auxiliary to the Waukesha County Medical Society met in the afternoon of June 5 at the home of Miss Hertha Voje, Oconomowoc, with Mmes. A. J. Loughnan and Henry A. Peters as assisting hostesses.

Since this was the first meeting held since December, Miss Voje, president, reviewed her work during the past year, reporting upon the state board meeting held in Milwaukee in February, the Hall of Health sponsored by the Milwaukee Medical Society and Auxiliary in connection with the Centennial, and various other meetings which she had attended. Mrs. Loughnan, in her report as philanthropic chairman, stated that all the boys at the Wisconsin Farm and Home School at Dousman are being remembered on their birthdays by the Auxiliary. Mrs. James Hassall reported 15 subscriptions to Hygeia.

The following officers were elected for the coming year: Mrs. W. H. Oatway, Waukesha, president; Mrs. W. D. James, Oconomowoc, president-elect; Mrs. C. C. Edmondson, Waukesha, vice-president; Mrs. Henry A. Peters, Oconomowoc, recording secretary; Mrs. Henry Settlage, Waukesha, treasurer. Mrs. Oatway announced a partial list of committee chairmen as follows: Archives and history, Mrs. J. B. Noble; philanthropic, Mrs. A. J. Loughnan; press and publicity, Mrs. Gwilym Davies; membership, Mrs. F. G. Zietlow; corresponding secretary, Mrs. G. W. Lawler.

Following the business meeting Miss Voje presented Mrs. J. C. Frick who reviewed, "Test Tubes and Dragon Scales" by Dr. George Basil. This book written about three years ago, reported Doctor Basil's experiences as a doctor in a Chungking hospital prior to 1932.

CONVENTION NOTES

Mrs. William C. Liefert, Convention Chairman, announces that plans for the Convention to be held in Milwaukee at the Hotel Schroeder on October 6, 7 and 8 are nearly completed and that the preliminary program will be published in the next issue of the *Journal.*

* * *

Reminder to County Presidents—Please send names of Convention delegates to Mrs. Arthur J. McCarey, State President, in care of the State Medical Society office before August 1 in accordance with her letter of July 1.

* * *

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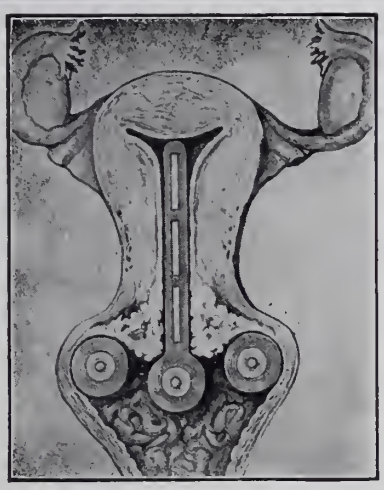

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THE JOURNAL BOOKSHELF

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, S. M. I. Building, Madison, Wis.

Clinical Electrocardiography. By David Scherf, M. D., F. A. C. P., Associate Professor of Medicine, New York Medical College, Flower and Fifth Avenue Hospitals; and Linn J. Boyd, M. D., F. A. C. P., Professor of Medicine, New York Medical College, Flower and Fifth Avenue Hospitals. Ed. 2. Pp. 267 with 243 illustrations. Philadelphia, London, and Montreal: J. B. Lippincott Company, 1946. Price $8.00.

This New American Edition of "Clinical Electrocardiography" is a worthwhile, well-written book. The authors have done well in reaching the goal expressed in the preface of "close correlation between electrocardiographic findings and their clinical evaluation." The descriptions of the various electrocardiographic alterations, including rhythm disturbances, are closely interwoven with the history, physical findings and drug action, and are clearly presented. Theoretical pros and cons are interestingly discussed with ample presentation of controversial and challenging concepts and their physiological implications. The illustrations are well chosen, well placed in the text, and timely use is made of the chest leads. If for no other reason, the authors' repeated emphasis that the electrocardiogram supplements but never supplants the result of clinical examinations, would alone recommend this book. It is highly recommended.—H. H. S.

Recent Advances in Obstetrics and Gynecology. By Aleck W. Bourne, M. A., M. B., B. Ch. (Camb.), F. R. C. S. (Eng.), F. R. C. O. G., Obstetric Surgeon to St. Mary's Hospital; Consulting Obstetric Surgeon, Queen Charlotte's Hospital; Consulting Surgeon, Samaritan Hospital for Women; Late Examiner to the University of Cambridge and the Conjoint Board, and Leslie H. Williams, M. D., M. S. (Lond.), F. R. C. S. (Eng.), F. R. C. O. G., Obstetric Surgeon to Out-Patients, St. Mary's Hospital; Consulting Obstetric Surgeon, Queen Charlotte's Hospital, The Jewish Maternity Hospital and The Nelson Hospital; Surgeon to In-Patients, Samaritan Hospital for Women; Examiner in Midwifery and Gynecology to the University of Cambridge and to the Conjoint Board. Ed. 6. Pages 357 with 77 illustrations. Philadelphia: The Blakiston Company, 1945. Price $5.50.

"Recent Advances in Obstetrics and Gynecology," by Bourne and Williams, edited by The Blakiston Company, Phila. is a very excellent review of the recent advances in obstetrics and gynecology and I recommend this book to all those interested in obstetrics and gynecology.—R. E. C.

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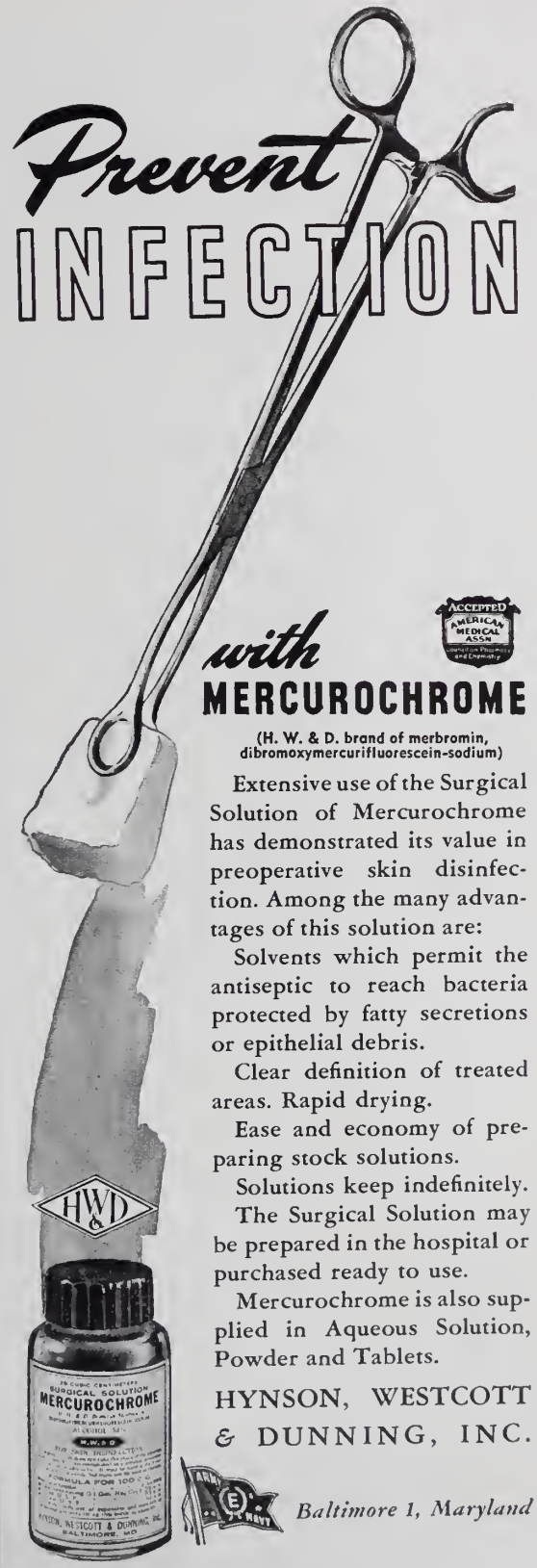

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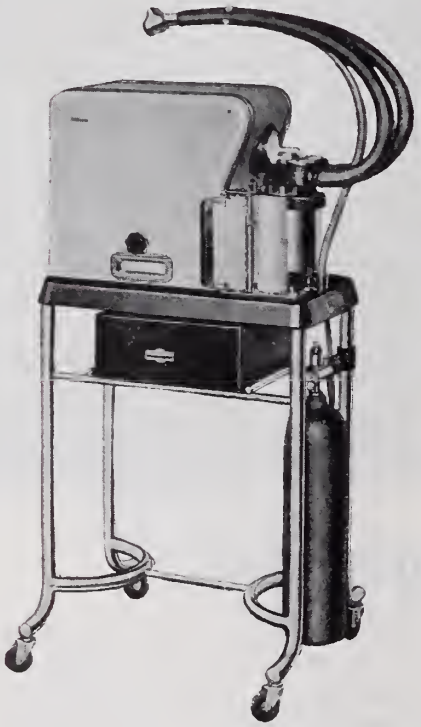

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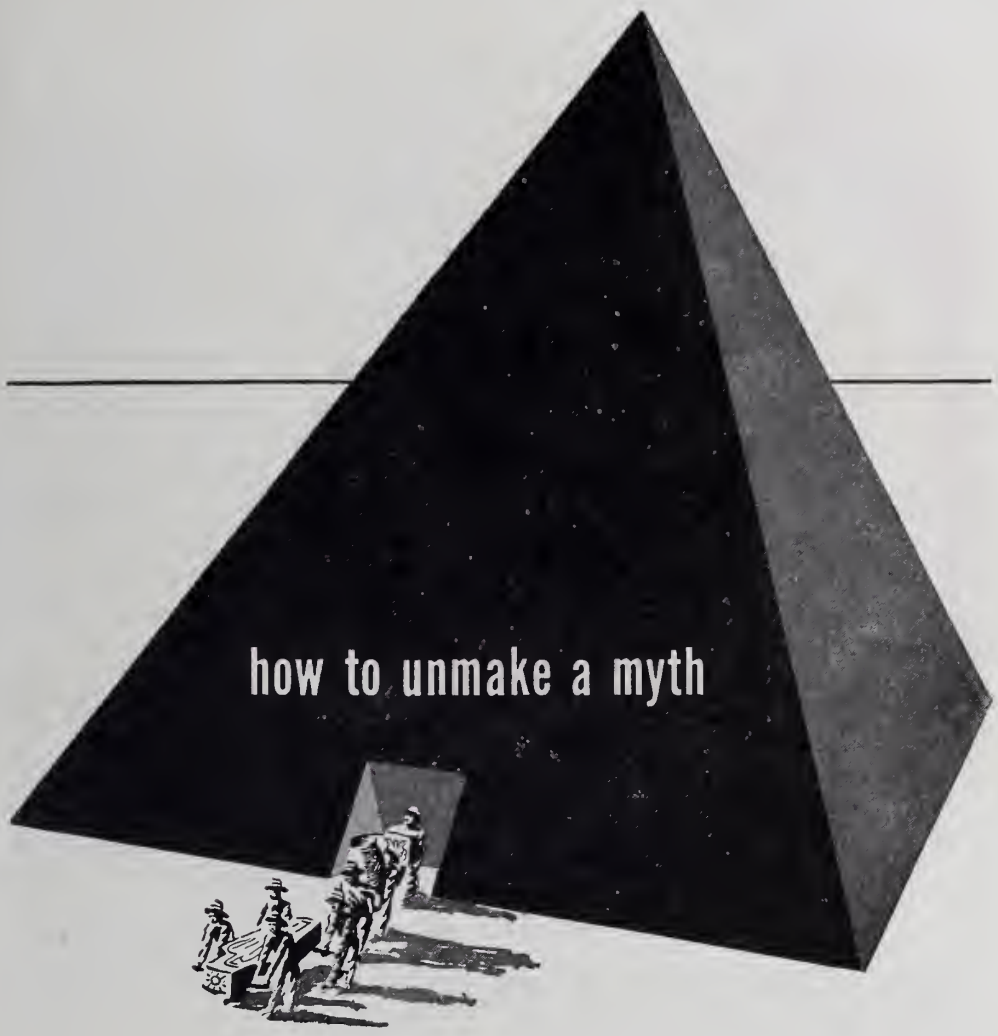

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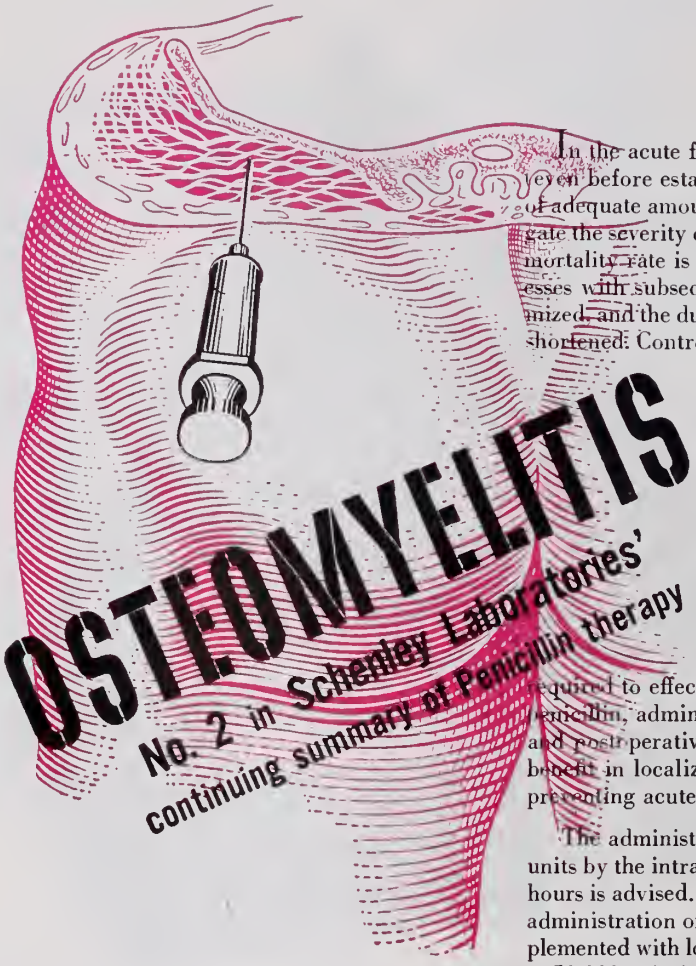

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KEEFER, C. S. *Penicillin—Its Present Status in the Treatment of Infections: The Nathan Hatfield Lecture XXIX, Am. J. Med. Sc. 210:147 (Aug.) 1945.*

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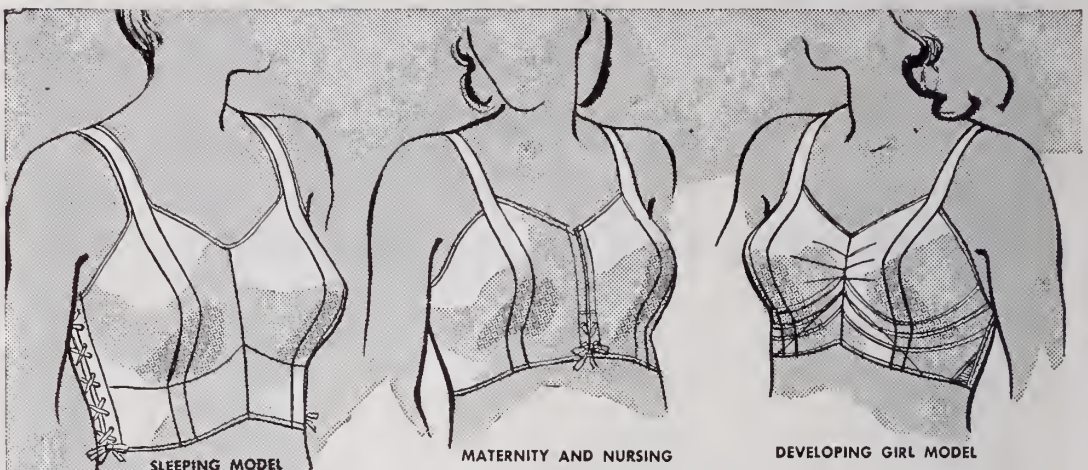

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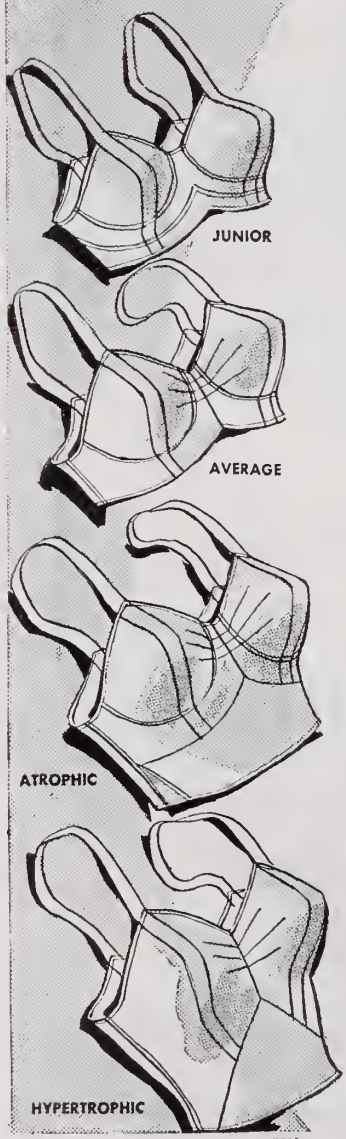

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The Possibility For Postgraduate Education in the Small Hospital

By THOMAS J. SNODGRASS, M. D., F. A. C. S.
Janesville

T. J. SNODGRASS

Doctor Snodgrass received his degree from the University of Minnesota and became associated with Dr. J. F. Pember and Dr. T. W. Nuzum of Janesville. After service in France during World War I, the doctor resumed practice and helped found the Pember Nuzum Clinic, where he is in charge of surgery.

He is a fellow of the American College of Surgeons, Diplomat of the American Board of Surgery, and a member of the American Trudeau Society and the Western Surgical Association.

FOR several years before World War II, I exchanged reprints and occasional letters with Dr. Henry Walter, of Paris and Vichy. Doctor Walter was working on the subject of calcification of the gallbladder, and originally had requested a reprint of my article on that subject, which was published in *The Wisconsin Medical Journal* in August, 1934. His article "La Lethiare Biliarie Calcique," was published in July, 1937, in the *Annales de Medecine.* In his last letter he said, "The Boche is coming over again and that will mean no more scientific work. I will have to go back into the Army."

During the war, it has been difficult to maintain an adequate program of education in the small hospital because of the depletion of the staff, increased responsibilities of the remaining doctors, and the ever present concern about the progress of the war. Most of the important meetings have been canceled, and those held have been devoted largely to war surgery or medicine.

It is now time to initiate a program of postgraduate education that will insure the degree of efficiency, on the part of the staff, that is demanded of the modern hospital. This is particularly important at this time because of the pressure on the part of certain groups for socialized medicine, the competition of the large state and government hospitals, and the rapid progress that is being made in the science of medicine.

The effectiveness of any program is in direct proportion to the cooperation between individual staff members. I have long been associated with a group practice and interested in the work of many groups throughout the country. The great advantage in this type of practice is elimination of competition, with the resulting pooling of interests, and the complete cooperation between the various medical specialists in the care of the patient. Diagnostic and educational facilities which are not available to the individual practitioner can be maintained by a group of physicians. With properly functioning groups distributed throughout the country, there could be little or no excuse for the government to establish diagnostic centers such as are advocated by those proposing government supervised medical practice.

Where the medical staff of a small hospital is made up of individual practitioners, the educational program must center around the hospital. A well-planned program will do more than anything else to bring the staff into proper cooperation. With each doctor responsible for his share of the work and expense connected with the maintenance of such a program, the work will go on efficiently and smoothly.

Monthly Staff Meeting

Most hospitals are, or aspire to be, accredited by the American College of Surgeons; and the monthly staff meeting, as prescribed by this body, is devoted entirely to the work of the hospital. The statistics, by departments, are reviewed for the previous month. Deaths and autopsies are reported in detail when of special interest, but routine cases may be passed over quickly to save time for more important discussions. It is a good plan to divide the meetings of the year into medical, surgical, obstetrical, and others; and have the chairman or committee in charge of that branch of hospital service put on a program in which the statistics for the entire year are reported, together with mortality and morbidity rates, a discussion of outstanding cases, and the progress made in that department. If these statistics are properly collected and presented, there will be sufficient material for staff meetings during the entire year. The staff meeting is not a place for

APPENDICITIS

Case No.	Doctor	Month	Age -10	10-19	20-29	30-39	40-49	50-59	60-	Sex	Days in Hospital	Previous Attacks	Pain	Nausea	Tenderness	Rigidity	Duration of Onset	Temperature	Pulse	Pre-Op. Complications	W.B.C.	Poly	Casts	Albumin	Sugar	Pre-Medication	Anesthetic	Points of Interest

HERNIA

Case No.	Name	Address	Age 0-10	10-19	20-29	30-39	40-49	50-59	60-	Sex	Days in Hosp	Occupation	Previous Operations: Date	Previous Operations: Time of Recurrence at previous operative site	Type of Hernia: Inguinal	Femoral	Umbilical	Epigastric	Ventral	Incisional	Spigelian	Scrotal	Sacrum	Diaphragmatic	Lumbar	Bilateral	Reducible	Irreducible	Duration: Years	Duration: months	True Hernia: Successful	True Hernia: Unsuccessful	Typ Ing.: Halsted	Bassini	Ferguson or Andrews	Repair

GALL BLADDER

Case No.	Month	Age	Sex	Duration of Illness	Previous Attacks	Temp.	W.B.C.	Urine	X-ray	History and Physical: Chief Complaints	Outstanding physical findings	Preparation for Surgery	Pre-Medication	Anesthetic

Fig. 1.

outside speakers or formal papers, but an excellent discussion can be prepared in connection with the presentation of a single interesting case.

Weekly Pathologic Conference

The weekly pathologic conference offers an opportunity for postgraduate education in this most important branch of medicine and surgery. Examinations for certification by specialty boards cover gross and microscopic pathology, both in the written and practical part of the examination; and it is only by seeing and handling the specimens and studying them through the microscope, that one may obtain a sufficient degree of knowledge and familiarity with pathologic specimens to pass a creditable examination. Every doctor aspiring to practice a specialty, whether in a small or large hospital, ought to be certified by one of the boards. The public and the hospital have a right to that assurance of competency on the part of the men practicing in the institution. The weekly pathologic conference offers an opportunity for members of the staff to see the type of work that is being done in the hospital. Presentation of the pathologic specimens, together with a review of the history, clinical findings, x-rays, and subsequent discussion, will be stimulating and instructive. The fact that this is a pathologic conference does not preclude the presentation of interesting medical cases where special diagnostic problems or methods of treatment are involved. The pathologist, however, should present the routine specimens removed by surgery or autopsy at this conference, and devote the time necessary to familiarizing the members of the staff with the pathologic specimens.

Tumor Clinic

In no phase of medicine is the education of the public and the physicians more important than in the field of cancer. The tumor clinic has for its purpose the utilization of the various specialties in the diagnosis and treatment of cancer. If the cancer clinic is devoted to the study of case histories after the patients have died or left the hospital, it is nothing more than a phase of the pathologic conference. The discussion and demonstration of excised tumors and biopsy specimens properly belong to the pathologic conference. The tumor clinic should be a place where the members of the staff can bring patients or problems for consultation with a pathologist, roentgenologist, surgeon, or any other specialist on the staff who may be of assistance in making the diagnosis or planning the course of treatment.

The Field Army does splendid work in educating the public on the subject of cancer and emphasizes the importance of regular examinations for the purpose of discovering cancer in its early stages. Recently, with the aid of staff members in several hospitals, tumor clinics were established for the purpose of making available to the public, free examinations to further assist in cancer control. It is the general policy to refer the patient back to his family doctor if anything of importance, or of a

Other Surgery	Pathological Report: Appendix	Pathological Report: Other Tissue	Death and Cause	Drainage	Final Diagnosis	Working Diagnosis

esthe-tic	Sutures Used	Complications: Respiratory	Complications: Gastro-intestinal	Complications: Genito-urinary	Complications: Vascular	Complications: Wound infection	Results-Patient's Statement: Type of Work	Results-Patient's Statement: Any Bulging in Region of Operation	Results-Patient's Statement: Pain in region of Operation	Results-Patient's Statement: Any operation for repair of rupture since.	Results-Patient's Statement: Testicle	Results-Patient's Statement: Success	Remarks

Operation: Surgery Done	Kind	Place	Primary Closure	Smooth	Respiratory	Convalescence: Complications: Cardiac	Genito-urinary	Wound In-fection	Disten-sion	Shock	peri-toni-tis	Hernia	Jaundice	Post-Operative: Days in Hospital	Mortality	Relief of Symptoms

suspicious nature, is found in the examination. There are objections to this method of handling such a program. In the first place, it is difficult to take a proper history and do a complete physical examination under conditions prevalent in a free clinic. In the second place, if the family doctor, in his own office, is not competent in making a diagnosis of cancer and it is necessary to set up a special clinic for that purpose, why refer the patient back to the family doctor? Why not take over the treatment as well? It would seem much more logical to have the publicity aimed at getting patients to their doctors at regular intervals for examinations, and then establish a well-organized tumor clinic in the hospital, where the doctor can refer his patient for consultation without charge after an adequate history and physical have been completed. Such a clinic should be held often enough to take care of the work efficiently, and without too much delay.

Surveys

From an educational as well as a practical standpoint, results obtained from medical and surgical treatment are the most important. Only from an accurate survey of mortality rates, morbidity, and end results, and a comparison with other institutions, can the members of the staff evaluate the quality of their work. The layman feels that in the hospital he will receive all the benefits of modern medical and surgical treatment. He does not realize that bad treatment is just as disastrous in a hospital as in the home.

For the past three years, the Rock County Medical Society surgical committee has conducted surveys; the first on appendicitis, the second on gallbladder disease, and the third on hernia. It was necessary to go back over every history for the period designated, and search out the necessary material in each case, and many times the information was extremely meager. The information and experience gained by this work was of enormous value. A need for a perpetual survey of every branch of the surgical service was very evident. It was further apparent that without a proper follow-up system, only a fraction of the value could be obtained from these surveys. Fig. 1 shows the outline of the work sheets used in the survey on appendicitis, gallbladder disease, and hernia. Fig. 2 shows the follow-up letter used in the hernia survey. No follow-up letter was used on the other surveys. If a system such as this is worked out in all branches of the medical and surgical service, there will be plenty of material on hand for all of the staff meetings held during the year. This material may also be used as a basis for worthwhile contributions to medical literature.

Student Education

The preceptor system of the University of Wisconsin brings students into small hospitals for periods of training. It appears sometimes that this may be more for the education of the doctors than the students. At least it is stimulating to have these young men with us. The students are helpful

MERCY HOSPITAL

Department of Surgery

Janesville, Wisconsin

Dear Former Patient: Some time ago you had a hernia (or rupture) repaired at the Mercy Hospital in Janesville, Wisconsin. We are making a survey of all such operations done here in order to determine how satisfactory our surgical repairs have been. I would therefore appreciate your answering the following questions.

1. What type of work have you done since your operation?
2. Have you had any pain in the region of your operation?
3. Is there any bulging in the region of your operation?
4. Have you had any operation for repair of your rupture since your operation here?
5. (For men only) Has one or have both of your testicles decreased in size since the operation? Has either of them been swollen?
6. In your judgment was your operation a success? If not, why?
7. Have you any other remarks to make?

An addressed envelope is enclosed for your convenience in replying, and I shall appreciate an early reply.

Very sincerely yours,

SISTER MARY TIMOTHEA, R. S. M.

Superintendent

Fig. 2

in carrying out the educational work of the staff. They assist in conferences and meetings and give valuable help in conducting surveys and reviewing literature in connection with the presentation of cases. Many small hospitals do not have interns or residents. This is largely due to the lack of education facilities developed by the staff.

It is important that the staff or hospital make available to these young men a library of sufficient size to furnish proper reference material. Doctors are notorious book-buyers and takers of magazines. Just a moderate pooling of resources will produce an excellent library of good books and current literature.

Public Education

The medical staff of the hospital in the small community has a responsibility for the education of the public in public health and medical affairs. Most of this is accomplished by personal contact but talks over the radio, in the schools, and at civic clubs are effective, if planned by the staff and carried out by competent men. An individual practitioner doing this on his own initiative may be criticized by the profession. It may not be out of place to suggest that the medical profession, as groups or societies, invest some money in educational advertising in the public press. If it was necessary to have cooperative advertising to sell War Bonds, it might be advantageous to try selling the public a program of health and medical service.

Annual Clinic

Every well-organized staff should make a practice of putting on at least one clinic each year for visiting practitioners and outside doctors. In the special August, 1945, number of the *Bulletin of the Jackson Clinic*, the editor has published papers given recently to groups of Wisconsin surgeons in two hospitals of the state. Both of these programs, as well as other programs which I have attended, would have done credit to any institution in this country. In each case the entire staff of the hospital took part in the program, and it was not restricted to members of the society being entertained. If the doctors avail themselves of the opportunity to visit and see the work of the staffs of nearby competing hospitals, it may be discovered that it is not always necessary to travel great distances to learn something new.

County Medical Society

Very closely related to the work of the staffs of the hospitals in smaller communities is the county medical society. Much of this program can be carried out on a county-wide basis with better results, because of the greater number of patients. Most county societies are satisfied to have a good outside speaker for the monthly programs, and do not favor the use of local men. Here in Wisconsin, we have the advantage of being near a large number of medical schools and have the choice of authorities in all branches of medical science. There should be a place, however, on the medical program of the county society for members who are anxious to prepare case reports or papers on subjects in which they have had considerable experience. Any properly planned and timed medical program can include more than one speaker without detracting from the value of the meeting. The county society should be a proving ground for men who have the ambition to develop their ability as speakers and teachers.

A program such as outlined here is very pretentious, and cannot be carried on without adequate help. For the average 100 bed hospital it will take at least two well-trained, full-time record clerks and statisticians to keep up the statistical surveys and send out the follow-up letters. These records must be filed so that they are available for study by members of the staff or committees, such as the surgical committee, or the medical committee. Besides the usual laboratory and x-ray technicians, a pathologist should be regularly employed and should spend enough time to take part in all conferences and

staff meetings. He should conduct, or supervise, most of the autopsies. Where there are several hospitals in a county or in a given area, cooperation between institutions makes it possible to have pathologists available practically the whole time. The same is true of the roentgenologist, key man in diagnostic work, treatment, and the educational work of the staff. The roentgenologist, however, has a better opportunity to carry on a private practice in his specialty, and is usually available to the hospital. However, if this is not so, again there is an opportunity for hospitals in nearby communities to cooperate with each other in their program of service and education. At this point, someone will be wondering about expense. How can a small hospital afford all this service? A small hospital cannot afford to be without these services, for without them, proper work cannot be done. One could cite the American public's annual bill for chewing gum, or cosmetics, or even for the reclaimed golf balls used by the doctors of the state during one season; however, this is not necessary in this discussion. Just for a suggestion as to the possible source of sufficient funds to carry on such a program, the incomes of four doctors in a typical staff were taken as an example; one in the upper brackets, with outside income; one in the lower brackets; and two in the middle. These were averaged, and the figure multiplied by 25, assuming 25 members in the staff of the hospital under discussion. If these figures are at all accurate, this group of doctors would pay, under present schedules, approximately $120,000 federal and state income tax. We hope the income tax will be reduced somewhat, but we know that it must stay at a high level for a long time to come. Paying one's share of the expense of maintaining these special services would not even be classified as a contribution, but as a necessary business expense. One can go a little farther and show that, with a net income between $4,000 and $6,000, it would cost only about $70 to contribute $100 toward this expense. The cost of a like contribution in other income brackets is shown in the following table:

Income	Cost of $100 Contribution
$ 4,000 to $ 6,000	$71
6,000 to 8,000	66
8,000 to 10,000	62
10,000 to 12,000	57
12,000 to 14,000	50
14,000 to 16,000	46
16,000 to 18,000	43
18,000 to 20,000	40

Many hospitals can afford to pay part of this expense from their gross income, especially now that hospital insurance has reduced the large loss ratio on accounts. Certainly the cost of this suggested program, together with many projects not even suggested here, would be very small compared to the figure just given, and every cent would be spent for the benefit of the public as well as the medical profession. It is the responsibility of each doctor, when he assumes the care of a patient in a hospital, to see that modern scientific medical care is available. The planners want it that way. It is our responsibility to see that they get it.

Modern Therapy of Trigeminal Neuralgia

By HARRY P. MAXWELL, M. D.
Milwaukee

H. P. MAXWELL

Doctor Maxwell, a 1941 graduate of the University of Chicago began his practice of neurological surgery in Milwaukee in October, 1945.

The doctor is now on the associate staff at St. Luke's Hospital, Milwaukee, the associate staff of the Milwaukee County Hospital, the adjunct staff of Milwaukee Children's Hospital, and instructor in clinical surgery at Marquette University School of Medicine. He is a member of the Chicago Neurological Society.

IN THE past there has been an abundance of literature on the subject of facial pain, especially with regard to trigeminal neuralgia, tic douloureux, or trifacial neuralgia, all synonyms for the same condition. The purpose of this paper is to present the general medical man with a short summary of the essentials of this disease, with emphasis on diagnosis and the accepted modern therapy.

Diagnosis

By definition, trigeminal neuralgia is a severe, sharp, and paroxysmal pain in the face. It is most commonly seen in people over 50 years of age, but may start in early adult life. It may be characterized by the presence of a "trigger zone" usually somewhere about the mouth or cheek, and stimulation of this "trigger zone" by cold wind, washing the face, talking, opening the mouth, chewing, or by movement of the tongue, will provoke the pain. In other instances, no "trigger zone" exists, and the paroxysms occur spontaneously. The important diagnostic point is the paroxysmal nature of the pain. The distribution of the pain is unilateral, most often along the branches of the second (maxil-

lary) or third (mandibular) divisions of the trigeminal nerve, therefore, the lower jaw, teeth (present or not, the pain may feel as though it is in them), tongue, lips, cheek, side of nose, and temple, are the favorite sites for this unbearable pain. Occasionally the first division fibers are involved and then the pain is in the eye or forehead above the eyebrow. Pain in the throat, behind the ear, in the neck, or back of the head, is not present in true trigeminal neuralgia. Further aid to a proper diagnosis is that the pain is neither constant nor dull, but instead is usually described by the patient as either a sharp, stabbing, burning, knife-like, jabbing, stinging, jerking, or instaneously shocking pain. Paroxysms of pain may come in series and the patient has to stop what he is doing, may move his head quickly as though in rebound to an unseen blow, or attempt counter-irritative measures such as rubbing the face or chewing movements. Between paroxysms the patient may be absolutely free from pain for days, weeks, or months, and once again will be able to eat, talk, wash the side of his face, shave, and enjoy life. But unfortunately the pain inevitably returns, and if it is severe, may endanger the health of the patient. Because patients are afraid to eat or drink during an exacerbation, dehydration and malnutrition may ensue unless measures for relief are undertaken.

Differential Diagnosis

The cardinal point in the differential diagnosis of trigeminal neuralgia from other lesions affecting the fifth nerve, is that the examination of the patient reveals no neurologic changes. Thereby the physician may be able to easily distinguish it from carcinoma, usually metastatic and oftentimes a direct extension from the nasopharynx, CNS lues, syringobulbia, syringomyelia, multiple sclerosis, and intracranial aneurysm. In each of these, subjective numbness, objective sensory loss, loss of the corneal reflex, associated ocular palsies, and other gross neurologic findings will point to the most probable diagnosis. An x-ray of the chest and skull may be of further aid if cancer is suspected.

Treatment

Apparently the inciting cause of trigeminal neuralgia, which is still a mystery, must have the peripheral pathways functioning in order for a paroxysm to be induced. Therefore anything which interrupts these pathways from the periphery to the central nervous system centers for pain, will prevent pain.

Novocaine block of the branches of the trigeminal nerve will stop it for a few hours. The safest nerves for injection are the supra-orbital, infra-orbital, and mandibular, each at its corresponding foraminal exit from the skull.

Eighty to 95 per cent ethyl alcohol injected directly into the nerve will succeed until the peripheral nerve regenerates, usually in about six to fifteen months. A second injection may then be done but is less likely to succeed as the nerve is usually then encased by and infiltrated with scar tissue and the alcohol will have difficulty in permeating through to all of the nerve fibers.

Alcohol injection of the gasserian ganglion may be very dangerous and in the majority of instances is impossible to perform because of the anatomic relationship of the foramen ovale. Serious cranial nerve palsies have been reported as a result of alcohol accidentally injuring the brain stem or adjacent cranial nerves. Electrocoagulation of the ganglion, another blind procedure, is also in similar disrepute.

Trichlorethylene may be inhaled during a severe paroxysm for transient relief as palliation before the patient can reach a consultant.

Vitamin B has not been proved to be of specific service in the therapy of this disease. Recently ferrous carbonate has been reported as being somewhat palliative.

Surgical Therapy

When the patient desires permanent relief elective neurologic surgery is undertaken. The bloody and time consuming procedure of the early days of neurosurgery have been replaced by modern technic. The operation of choice is the classical temporal approach to the sensory root. An interruption of the fifth nerve central to the gasserian ganglion, retrogasserian neurotomy, will be permanent and no regeneration can occur. The operation is done with the patient sitting up and local or general anesthesia may be used.

The gasserian ganglion is exposed extradurally by elevation of the temporal dura mater from the floor of the middle fossa. In the process the middle meningeal artery is secured by plugging the foramen spinosum with cotton before division of the artery. After the ganglion is exposed, its sheath is opened and the sensory root is avulsed, sparing the motor root. If no pain has been present in or above the eye, a differential sectioning of only the second and third divisions is preferred as sensation will be preserved in the eye and the danger of corneal ulceration obviated. Very rarely a transient facial palsy may complicate the temporal operation from traction on the superficial petrosal nerves, but in a clean dissection of the ganglion this danger is remote.

There is another surgical approach to the sensory root by way of the posterior fossa, but as the distance to the nerve is so great, and as other vital structures are exposed to possible trauma, as well as the fact that the petrosal vein may have to be divided and severe vertigo from interference with the venous drainage of the dentate nucleus of the cerebellum may result, we have not used this route.

Although the pain is unilateral, it has been seen in a few instances in patients who have had a successful operation on one side, to recur on the other side of the face years later. This type of case taxes the ingenuity of the surgeon because he is loathe to leave the patient with a completely anesthetic mouth from cutting both sensory roots. Also, the temporal operation may expose the motor root to trauma and if both motor roots were to be damaged, whether by surgery or by a deep third division alcohol injection, a jaw drop might result and chewing be difficult or impossible.

Fortunately a new surgical procedure, *medullary tractotomy*, has been found useful in recent years in attacking the problem of intractable pain in the face, and is especially helpful in a case of recurrent bilateral tic douloureux. In this operation a sectioning of the descending spinal tract of the fifth nerve is made in the medulla oblongata. There is one area, 4 mm. below the caudal end of the fourth ventricle and 7–11 mm. lateral to the mid line, where this tract comes to the surface of the medulla. A cut to a depth of 4 mm. will abolish pain and temperature sense in the face and leave touch and pressure sensation intact. Several of us have been fortunate enough to have worked with Drs. Eric Oldberg, Percival Bailey, and Paul C. Bucy, at the Illinois Neuropsychiatric Institute of the University of Illinois, on patients on whom this operation has been done. Doctor Bucy in particular, is interested in the problem of exactly where the descending spinal tract should be sectioned. As cerebellar and pyramidal motor pathways are spared, ataxia and weakness are not a complication, and the motor root to the muscles of mastication is not exposed to danger. Thus the patient is still able to handle food and drink and feel objects touching the face, eye, and inside of the mouth, on the side of the section.

This operation is best done under endotracheal ether using the cerebellar route to the medulla. It has been used successfully on many occasions for trigeminal neuralgia and is also of similar value in cases of intractable pain in the head from involvement of the trigeminal, glossopharyngeal, and upper three cervical nerves in carcinomatous metastases. With one exposure, a medullary tractotomy, intracranial section of the glossopharyngeal nerve, and a rhizotomy of the posterior roots of the upper three cervical nerves can be done.

The mortality from any of the above accepted procedures is less than 1 per cent in good hands.

Conclusion

Immeasurable relief may be given patients suffering from the ravages of trigeminal neuralgia by the use of the present day rational therapy in the hands of competent neurologic surgeons.

Histoplasmosis; Report of Case With Autopsy*

By MAJOR LAWRENCE L. SWAN, (MC), AUS
and
CAPTAIN JOSEPH V. FINNEGAN, (MC), AUS

L. L. SWAN

A graduate of the University of Illinois, class of 1940, Doctor Swan entered military service in August, 1942, and was stationed at Fort Leavenworth, Kansas, as chief of laboratory service. Later he was assigned duty as pathologist at the Army Medical Museum, Histopathological Center, Fitzsimons General Hospital, Denver, and as surgical pathologist and assistant chief of laboratory service at Fitzsimons.

He is a member of the American Board of Clinical Pathology.

THE reported cases of histoplasmosis are appearing in the literature with ever increasing frequency, and it can no longer be considered a rare medical curosity. A recent review of the literature by Parsons and Zarafonetis,[1] beginning with the original description by Darling, lists 71 cases. Among the states listed, Wisconsin is not mentioned, although adjacent states have had several cases. It is the purpose of this paper to report an additional case of histoplasmosis with autopsy probably originating in the above state.

Case 3371—W.L. AMM Acc. No. 143880. This 49 year old white man was admitted to the hospital with a provisional diagnosis of gastro-intestinal malignancy with possible liver metastases. His chief complaint was distention, tenderness in region of spleen, and progressive weight loss of 29 pounds.

His present illness began six months prior to admission and was manifested by an acute onset with chills and a temperature of 104 F. In approximately one week the temperature had subsided to a daily evening elevation varying from 100 to 102 F. His local physician was consulted, and a smear for malaria was negative. He was found to be somewhat anemic, and was given nonspecific therapy such as liver extract and vitamin B with no ap-

* Acknowledgment: The writers would like to express appreciation for the advice and technical assistance of Colonel Hugh W. Mahon (MC), USA.

parent improvement. In view of the patient's lack of response to treatment "a change of climate" was advised.

Upon arriving in the state of Colorado, the patient immediately sought medical aid because of his continued downhill course. His appearance, to the referring physician, was suggestive of chronic tuberculosis. X-rays of chest failed to confirm this impression but there appeared to be "vague pathology" in the region of duodenal cap. No gastric analysis or cultures for tubercle bacilli were made. Serologic agglutinations were negative for tularemia, undulant fever and typhoid. Smears for malaria were again negative. He had a "deep seated" oral infection which was not cultured. Extractions were performed, and an unreported amount of penicillin administered. No cultures of gingivae were made.

Improvement was of short duration, and progressively severe chills and fever necessitated his final hospitalization.

From his past history it was learned that he had been a rural mail carrier, and his last occupation was factory work. He had never farmed nor was he exposed to animals. He stated that his mother and two uncles died of tuberculosis. There was no history of tropical service, venereal disease or operations. He had the "usual childhood diseases," and allegedly had malaria at the age of 21 with recurrence in 1927.

He was hospitalized for a severe respiratory infection, type undetermined, in 1932, and was reassured that it was not tuberculosis.

He suffered from sciatica and rheumatism since 1927, and entered a Veterans' installation in 1933, for physical therapy and general physical evaluation. Nothing significant was found.

He settled in the state of Wisconsin in 1937, where his initial symptoms developed approximately six months before his death.

On physical examination the patient was found to be critically ill and appeared to be markedly dehydrated and slightly icteric. Temperature rectally was 101.4 F., pulse 136, and respirations 22. A single blood pressure reading was: systolic 90, diastolic 40. Physical examination was negative except for observation that the patient appeared to be chronically ill. There were coarse rhonchi throughout both lungs, slight abdominal distention, and liver was palpable 2.5 cm. below the costal margin. The liver was smooth, nontender, and the spleen was not palpable.

By x-ray, there was evidence of pulmonary congestion in both bases and calcification of the aortic arch. There was no evidence of pneumonic consolidation.

He was repeatedly given 5 per cent glucose in normal saline and plasma. His condition became progressively worse and he expired at 9:30 p.m., 15 January 1945.

The laboratory findings were as follows:

Hematology

	RBC	WBC	Hb.	Neut.	L.	M.
1–12–45	5.0	11.9	78%, 12.1 Gm.	84	15	1

Urinalysis

Color	Char.	Reaction	Sp. Gr.	Alb.	Sugar	Micro.
Amber	Hazy	Acid	1.020	Neg.	Neg.	Neg.

Chemistry

	Alb.	Glob.	Total	Ratio
1–15–45	3.0%	2.8%	5.8%	1.1

Chemistry (postmortem)

	Urea N.	Chlorides	Sodium	Potassium
1–15–45	16	560	284	20.0

Blood Culture

1–13–45 No growth. 10 days

Stools

1–15–45 Neg. for occult blood.

Serology

1–15–45 Kahn-negative

Necropsy was performed eleven hours after the patient had expired. Inspection of the body confirmed the clinical impression of chronic, debilitating disease. The adrenal glands were markedly enlarged, grayish-yellow and of firm consistency with slight irregular nodularity of the surface. The right adrenal weighed 177 Gm. and measured 10.0 x 8.0 x 2.3 cm., and the left weighed 130 Gm. and measured 9.5 x 7.0 x 2.5 cm. Considerable resistance was encountered upon cutting, and cut surface was mottled with areas of soft yellow material in a matrix of firm, opaque white tissue. Peripherally, patches of brown cortical tissue measuring 0.05 cm. in width were seen. The mesenteric lymph nodes were slightly engorged. In the proximal loop of jejunum a 0.5 cm. superficial ulcer was noted on the crest of a plica circularis. The liver weighed 2,945 Gm. appeared to be markedly engorged but was otherwise normal. The spleen weighed 555 Gm. and no noteworthy lesions were noted. The lungs were voluminous, the right weighing 1,140 Gm. and the left 1,025 Gm. On palpation the lungs were subcrepitant, and from cut surface considerable blood-tinged fluid escaped. No noteworthy pathology of the buccal, mucous membrane or gingivae was noted.

The remaining gross findings were essentially negative. The gross impression was caseating tuberculosis of adrenal glands.

Microscopically extensive areas of conglomerate caseation were seen in which myriads of *Histoplasma capsulatum* were found in the cytoplasm of mononuclear macrophages and extracellularly. The organisms were also rarely found in surviving cortical cells. The granulomata were usually bounded by an irregular zone of reactive fibrosis with

tendency to palisade. Polymorphonuclear neutrophiles were present focally and diffusely. The focal collections were in the vicinity of bacterial colonies. A granulomatous area in the jejunal ulcer was densely infiltrated by mononuclear cells which were heavily laden with Histoplasma. Very rare organisms were found in macrophages in the sinuses of the mesenteric lymph node. No *Histoplasma capsulatum* was found in any other organ or in the bone marrow. No tuberculosis or other noteworthy pathology was noted.

Histoplasma capsulatum was successfully cultured from adrenal tissue. Mouse inoculation reproduced the disease and organisms were easily demonstrated in mouse tissues.

Summary

A report of case and autopsy of histoplasmosis, from which *Histoplasma capsulatum* was cultured, is described with adrenal pathology closely resembling tuberculosis. There was no other noteworthy gross pathology. The epidemiology of this case is uncertain; however, the disease apparently originated in Wisconsin. No cases originating in the state of Wisconsin are included in the recent summary of "Histoplasmosis in Man," by Parsons and Zarafonetis.[1]

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STATE BOARD OF HEALTH ANNOUNCES NEW TRAINING ALLOWANCE POLICY

A training allowance of $360 per month is being offered by the State Board of Health for postgraduate training in public health. This stipend, plus tuition and the cost of travel, is being offered to those physicians selected as district health officers under the state's civil service requirements.

One or two full semesters of training at a university having an accredited public health course will be offered to those who qualify for district health officer positions. Civil service requirements for these positions call for a license to practice medicine in the state of Wisconsin or eligibility therefore, and preference is given for veterans.

Due to the extreme shortage of medical personnel, the age limit on the selection of physicians for training has been raised to fifty years; however, preference will still be given to those applicants in the younger age groups.

Upon completion of their training, the physicians will return to Wisconsin and be placed in charge of one of the state's ten district health offices to direct a program of public health activities.

Physicians interested in applying for the training or desiring more information about it should write the State Board of Health, Madison, Wisconsin.

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

More on Folic Acid

More interesting recent reports on the use of folic acid in pernicious anemia (Addisonian) are presented,[1,2] adding to the previously available literature (see Beckman—Comments on Treatment, May, 1946).

The initial daily dosage employed by Kaufmann and Schwager ranged from 20 to 40 mg. orally and as the erythrocyte count approached normal, a reduction of dosage to 5, 10 or 15 mg. seemed to be an average maintenance quantity. The rise in red cell count approximated 90,000 per cmm. per day, while the hemoglobin rose 1 per cent daily, leading to a color index below 1.

These authors believe that in many instances folic acid may be used in place of the commonly used liver therapy; it has the great practical advantage of promptness and painlessness and appears to be free of untoward side actions. However, there is no evidence that folic acid will do more than liver preparations so that relapse may be expected if treatment is stopped. These observers have, so far, not found it necessary to administer supplementary dietary measures, other vitamins, or hydrochloric acid, but obviously such adjuvants might be expected to be contributory to an even more satisfactory response, perhaps in the nature of a more rapid approach to normal.

Doan reports a series of 10 cases of pernicious anemia (Addisonian) in which satisfactory responses were obtained, whereas, other types of anemia do not appear to be amenable to this type of therapy. This author believes that from all information available the L. casei factor (folic acid) favorably affects all human macrocytic anemias; hence the factor presumably operates on the megaloblastic maturation process preventing anomalies of overgrowth. The dosages required by oral or intravenous route are essentially equal but differ significantly in different individuals, varying all the way from 1 mg. to 25 mg. daily. Since overdosages up to 125 or 150 mg. are usually well tolerated, the margin of safety between the minimal and maximal dosages is satisfactorily large.

The relationship of folic acid to the factors in liver extracts has not as yet been established, while required dosages tend to indicate that what actually operates may be some more potent combination of folic acid with other and unknown complexes.

One is tempted to speculate as to the cause of deficiency of this peculiar and highly specific substance. Kaufmann and Schwager state that the folic acid content of sweat, obtained from profuse perspiration, is much higher than that contained in the urine. Is this type of anemia due to excessive loss of folic acid through excretory channels; is there an excessive loss within the intestinal tract, or are there present substances that destroy or antagonize it? One is reminded of the apparently well established fact that in the anemia from the giant fish tapeworm infection in man, the manifestations are essentially identical to pernicious anemia, even to response to liver injections. In this case it suffices to remove the worm. Other blood-sucking worms, such as the hookworm, do not cause this type of anemia. Is it that in the case of the anemia from the fish tapeworm, some substance, unique to this worm, is absorbed and uniquely affects the hematopoietic system or prevents folic acid from acting? In pernicious anemia is there an absence of folic acid in the intestinal tract and excreta? The field is wide open to the hematologist.
—A. L. TATUM.

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Notes on Clinical Pathology

Editors—WALTER H. JAESCHKE, M. D., University of Wisconsin, Madison, and
S. B. PESSIN, M. D., Marquette University, Milwaukee

Quantitative Urobilinogen Determinations

Quantitative urobilinogen determinations on urine and stool specimens are extremely useful in the differential diagnosis of jaundice.

Interpretation of results with quantitative procedures of Watson.

(1) *Normal values:*

Stool—40 to 280 mg. per day. Most values between 100 to 250 mg.

Urine—0.4 mg. per day. Most values between 0.5 to 2 mg.

(2) *Low urine and stool* values may be encountered in cases of anemia, inanition and inactivity.

(3) *Hemolytic jaundice*—An excessive destruction of red blood cells leads to the production of large amounts of hemobilirubin (plasma bilirubin) and correspondingly to the excretion of large amounts of cholebilirubin (bile bilirubin) in the intestine. Increased amounts of urobilinogen are produced by the action of anaerobic bacteria, and increased amounts are excreted in the stool; also, excessive amounts of urobilinogen are absorbed and carried to the liver. A normally functioning liver finds it possible to handle this excess and no urobilinogenuria results.

Hence, a jaundice mainly hemolytic in type shows the following:

Stool—high values.
Urine—close to normal values.

(4) *Hepatogenous jaundice*—In hepatogenous jaundice there may be normal or at times impaired excretion of cholebilirubin with a consequent normal or low urobilinogen determination on stool specimens. The absorbed urobilinogen is not handled too well by a damaged liver, and significant increases in urobilinogen are noted in the urine (urobilinogenuria).

Hence, hepatogenous jaundice in which the intrahepatic obstructive factor is not excessive shows the following:

Stool—normal to low values.
Urine—high values.

(5) *Obstructive jaundice*—Cholebilirubin is formed as usual, but none reaches the intestine. It follows, therefore, that no urobilinogen is formed and none appears in the feces or urine.

Hence, obstructive jaundice (complete) shows the following:

Stool—theoretically there should be none, but actually a few milligrams per 24 hours are found. It is thought that bile staining of the intestinal mucosa serves as a source for a fair period of time.

Urine—0 values.

(6) *Obstructive jaundice (Partial obstruction with no appreciable liver damage).*

Cholebilirubin is produced in average amounts, but only small amounts are available in the intestine for urobilinogen formation. This form of obstruction is often seen with a partially obstructing stone in the common bile duct.

Hence, obstructive jaundice (partial) with little liver damage shows the following:

Stool—low values. *Urine*—low values.

(7) *Obstructive jaundice (Partial obstruction with appreciable liver damage).*

Hepatogenous jaundice which always has some intrahepatic obstruction has the same laboratory findings as a jaundice caused by a partial extrahepatic obstruction (usually stone) associated with liver damage.

If careful clinical study of the patient fails to clearly differentiate between the two conditions biliary tract exploratory surgery is indicated.

Obstructive jaundice (partial) with appreciable liver damage shows the following:

Stool—low values.
Urine—high values.

(8) *Hemolytic jaundice with liver damage*—It should be obvious from previous discussions that the following results would be obtained:

Stool—high values. *Urine*—high values.

(9) *Hemolytic jaundice with extrahepatic obstruction.*

Congenital hemolytic jaundice is in rare instances associated with a partially obstructing stone in the common bile duct. If the obstruction is of a severe enough grade, it is obvious that confusing low values may be found in stool specimens.

(10) *Other conditions leading to increased urobilinogen production.*

(a) Anaerobic bacteria in infected biliary passages may change cholebilirubin into urobilinogen.

(b) Areas of infarction, hemorrhagic ovarian cysts, ectopic pregnancies, and others, are fairly common sources of hemoglobin leading eventually to increased urobilinogen production.

—WALTER H. JAESCHKE, M. D., *University of Wisconsin.*

. . . . THE PRESIDENT'S PAGE . . . .

The Logic of Facts

MEDICINE is an art built upon a foundation of scientific exactitude and a philosophy of cultural exercise and attainment. If it were entirely scientific, medicine would be a mechanical trade and not a profession. The experience of physicians has demonstrated that a psychic element enters into the consideration of almost every case in medical practice.

While excellent propagandists, the forces urging a federalized system overlook the psychosomatic quality of medicine and urge a standardized order where the fact would have to conform to the rule rather than the rule to the fact.

Standardization is the pet term of mass production mechanics. It contemplates an assembly of entities that constitutes a machine, every element of which is thoroughly understood and subject to replacement without destroying the machine's ability to function. The human body is mechanical in many respects, but it is also a laboratory of chemical activity and the repository of that intangible but vibrant entity that is called the mind—which has defied complete analysis notwithstanding its subjection to the scrutiny of all the philosophies of the ages. It can be influenced by suggestion, logic, and the various suasions, but is not amenable to enslavement.

At the Senate hearings on Bill S. 1606, the logic of facts was lost to the procession of groups, mostly small, deceptive in their designations, parading in the interest of feudalized medicine. The glib effrontery of some spokesmen of the larger organizations who presumed to speak for all the people in the country was in keeping with the kind of bill they supported. Against them ranged the great medical organizations and others alive to the thoughts and lessons of humanity. Probably no great group in American life could so nearly approach unanimity. To be sure, we have a sprinkling of the captious, the disgruntled, and the dissident, but it is unbelievably thin. The sponsors of compulsory medicine rounded up all these and other minor groups to testify before the Murray committee, that their high sounding designations might carry their cause along. And there were larger group officials, assuming to speak for all our citizens, who desire that medicine be rendered as impotent and servile as is their own membership.

We wish to remind all these that the psychic forces in human affairs may be restrained for a time by misrepresentation and violence, but in the long run it will determine not only the course of medicine but the destiny of all the complicated forces that constitute American life.

P. R. Minahan

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« « « EDITORIALS » » »

STATE BOARD OF MEDICAL EXAMINERS ALERT TO THE TIMES

In these busy days of practice, and of economic problems, many are prone to overlook the steadfast and loyal work of public officers on the needs of the times.

Perhaps the State Board of Medical Examiners needs no accolades from the medical profession. But it may not be amiss to emphasize just one of its many activities and the grand job that it is doing.

Under the state law, the Board is mandated to meet on two occasions each year, January, in Madison, and June, in Milwaukee. These meetings take the members of the Board away from their homes and their offices four to five days on each occasion as they spend many long hours interviewing applicants for licensure. And tedious time is later given to the grading of examination papers.

During these war-time years the Board has done more than duty requires. It has scheduled additional sessions at other periods of the year to facilitate the admission of veterans, particularly those applying on the basis of reciprocity. It has revised and streamlined its rules, and many a veteran physician in Wisconsin will testify that cooperation has been self-evident.

The medical profession and the public in equal measure owe a vote of thanks to this hard-working, conscientious group of physicians.

CAN DO

In the turmoil of crowded facilities and the confusion of a streetcar strike, the A. M. A. held its ninety-ninth Anniversary Meeting in San Francisco. Impressions are in order.

A Division of Public Relations, under the guidance of Dr. George F. Lull, secretary of the Association, is to assume the manifold responsibilities that in earlier years appear to have been divided somewhat unequally among the editor of the *Journal*, the Council on Medical Service and Public Relations, the Board of Trustees, and other official bodies of the A. M. A.

It is to be hoped, as it has been claimed, that this new division will tend to eliminate such confusion as may have hitherto existed, and that there will be correlation of all public relations activities.

It is an end to be desired, and it is an end that must be consummated in the interest of the health of the American people.

This *Journal* holds no individual beliefs but it supports now, as in the past, the pronouncements of the will of the majority. That is good fundamental doctrine in any organization.

After the editorial on the following page was printed, *The Journal's* attention was directed to a letter from Isidore Falk which was printed in full in the June, *Rocky Mountain Medical Journal.* This reply will be reprinted in the September issue of *The Wisconsin Medical Journal.*

THE POLITICAL MACHINE STILL AT WORK

The Rocky Mountain Medical Journal* performs a useful public service in providing its readers with information concerning the political machine behind the Wagner–Murray–Dingell bill. Summarizing facts presented to representatives of the medical profession from Colorado and adjoining states by Marjorie Shearon, Ph. D., research analyst for the Conference of the Minority, United States Senate, the Journal urges its readers to "think, speak, write, work, and tell the voters the truth—if we are able to save our profession in America!"

The story related by the Journal can hardly be summarized. It is given our readers virtually in full.

Isidore Sidney Falk, Ph. D., heads a machine to nationalize medicine. He is of foreign extraction, born in 1899, educated at Yale following which he taught at the University of Chicago for five years. Those who know him well describe him as brilliant, a hard and industrious worker and "clever as hell." He manipulates statistics to "prove" that which furthers his aims and desires. False claims regarding his "cure" for influenza led to his being fired from the University of Chicago and to his grudge against the medical profession. Dr. Falk then became the Director of Research for the Committee on Costs of Medical Care. Thus he has become classed as an "expert" on the basis of data which is outdated (if ever creditable) and some of which has been redated with obvious ulterior motives; he is one of the "overnight experts" readily available on any subject and in any field. He left the committee in 1933 and joined the Milbank Fund, associated with the since-deceased Director of Research. In 1935 he was given a year's leave of absence with pay and did a superficial job on European sickness insurance survey. And, of course, he wrote a book. Unfortunately, many of the fools who aspire to write a book ultimately do so; thus an expert may be created in less than overnight. The way was then paved to a position on the Social Security Board, even if it was in a minor capacity at first. But in 1940, four men ahead of him disappeared and Falk became Director of Research and Statistics—in perfect keeping with his sleight-of-hand manipulations. Here he kept health studies cornered. His Director of Economics was a benign-appearing woman whose equipment got her in places where his own was less appropriate; she gets for him the kind of "statistics" he desires. Another woman on his staff has been assigned to "bring along" the labor groups, some of which are joining the forces who want to nationalize medicine. She prepares speeches and testimony for the labor people. All of Falk's original staff have resigned because they won't be parties to his type of dealing, but there remain some lesser lights in the fringe of his orbit. They comprise a skillfully managed team of several dozen people who know their jobs and who do the will of their boss like trained animals. Regular research is quashed and workers do and find what their chiefs direct.

The Surgeon General of the United States Public Health Service was double crossed in 1939 when medical provisions of the Wagner Bill were subversively shunted to the Social Security Board. Falk smoothly altered it his way, and Dr. Parran has no illusions about him. In 1943 Falk fooled Parran again. Two new medical bills were prepared by Falk's outfit which claimed that the bills were only in the "study stage," and there was no immediate action brewing. But they had their case ready to spring. Next day a full-grown bill was introduced, the 1943 version of the Wagner–Murray–Dingell bill, and the Surgeon General hadn't even seen it. Later on, Dr. Falk went through the motions of confiding in the U. S. P. H. S. and it is the job of one of his staff members to act as a go-between with it and the Social Security Board. Similarly, Falk went through the motions of confiding in nurses and dentists—all, of course, for the purpose of aligning them on his side. Sadly we note that Dr. Parran has now joined the collaborators; he has sold out the medical profession; the screws were put on him and he yielded; he has done what he thinks his administration wants him to do. And thus a seven-billion-dollar insurance scheme may pass!

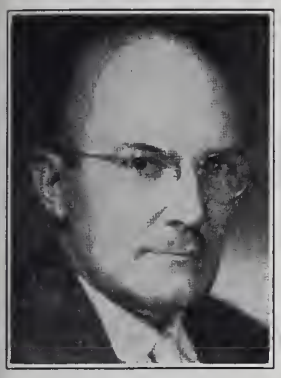
If it should pass, the plain fact is that the Social Security Board, with Falk the power behind that particular throne, would dictate to medicine in the United States. It would, by regulation, directive and edict, control every act of every physician, dentist, pharmacist, nurse *and every patient*. It would, after a few "introductrination years," control almost 25 per cent of the national income. This would be a tremendous step toward the totalitarian state. Call it national socialism, fascism, nazism, communism, or what you will, they all lead to the same thing. It has been officially noted in a Canadian study of European sickness insurance that during the early years of Hitler's regime, the German government's medical program was looked upon by many as one of the greatest props of the totalitarian state.

Politically the scheme appeals to some members of Congress as a means of raising money; it appeals to labor leaders because it gets votes. Since Falk is tireless and energetic, nice young U. S. P. H. S. men find it easier and more peaceable to let him have his way. The Doctor tells the world that some fifty other countries have "arrived" at this means of fulfilling their health requirements, but we are "coming along" and none of our difficulties are insurmountable. This is characteristic of his honeyed and perverted sales talk.

Dr. Shearon quoted a modern definition of democracy: "the greatest good for the greatest number—whether they want it or not." And in this democracy, while thousands of us were out of the country caring for the men defending it, and other thousands carried the load at home to back up the fight, this is what happened. Falk and his gang were lining up a job and a future for themselves, *not* for the benefit of the people of America.

This, gentlemen, is the way it stands; we have pointed out the enemy of our profession and of the American way to practice it . . . do all in your power to prevent scientific medicine and medical progress in America from following the Old World's mistake!

* Editorial, *Rocky Mountain Medical Journal*, April, 1946.



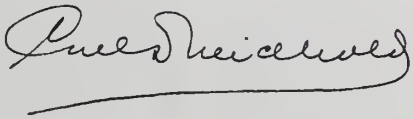
C. D. NEIDHOLD

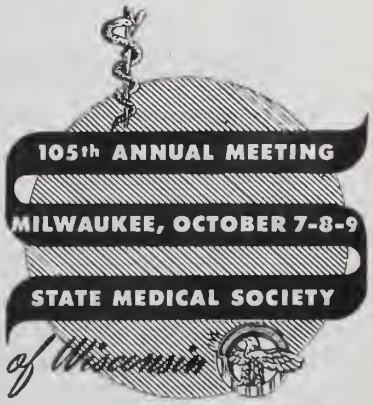
■ As chairman of the Council on Scientific Work, it is my distinct pleasure and privilege to direct the attention of all members of the State Medical Society of Wisconsin to the scientific programs which have been prepared by Dr. E. R. Schmidt, Madison, and the several chairmen of the sections.

Recognizing the renewed interest of all returning veteran members in advances which have been made in the science of medicine during the war years, Doctor Schmidt has prepared a program with fine balance between a "refresher course" for the general practitioner and the presentation of new subject material in various scientific fields.

It is the hope of the entire Council on Scientific Work that as many members as possible will attend the meetings planned. We urge you to earmark the dates of October 7–8–9 on your 1946 calendar so that you can plan your professional work in a manner to permit your attendance at the Annual Meeting in Milwaukee on those dates.

Cordially yours,





E. R. SCHMIDT

THE 105th ANNIVERSARY MEETING

Hotel Schroeder **Milwaukee Auditorium**

The One Hundred Fifth Anniversary Meeting of the State Medical Society of Wisconsin, to be held in Milwaukee October 7–8–9, 1946, will present many new features of interest to Wisconsin physicians.

The general scientific sessions, prepared by Dr. E. R. Schmidt, Madison, in consultation with the Council on Scientific Work, will present many outstanding papers on newer developments of medical science. Complete details of the scientific programs, including the section meetings, are included on the following pages.

Special attention is called to the fact that this year all section programs will be held *Tuesday* morning, instead of the morning of the closing day, as has been the custom for several years past.

The Council on Scientific Work also wishes to make special mention of the program being offered before the Section on Radiology. For several years the section program has consisted of interesting case studies of particular interest to radiologists. At the request of the Council, Dr. L. V. Littig, chairman of the Section on Radiology, has prepared a program *of special interest to general practitioners.* It is hoped that many physicians who have occasion to use radiology in their practice will attend the meeting being planned by Doctor Littig and his associates.

The specific problems of radiology, in the nature of case studies, will be discussed at two round-table luncheons, presented Monday noon under the chairmanship of Dr. J. E. Habbe, Milwaukee, and a second round table, Wednesday noon, under the leadership of Dr. E. A. Pohle, Madison.

If you are a delegate, please note that the opening session of the House of Delegates will convene Sunday afternoon, October 6, at 5 p. m. in the banquet room of the Hotel Schroeder. So please make your hotel reservations accordingly.

THE HOTEL ROOM SITUATION

We are asked by the Milwaukee Hotel Association and the Milwaukee Association of Commerce to inform all members that the hotel situation in Milwaukee is critical, and it is highly advisable that all physicians expecting to attend the Annual Meeting October 7–8–9 make their hotel reservations immediately. Delegates are expected to attend the initial meeting of the House on Sunday, October 6, at 5:00 p. m., so reservations of all delegates should begin with Sunday evening, October 6.

The official hotel is the Hotel Schroeder. If rooms are not available there contact the Housing Bureau of the Association of Commerce immediately and have your requests for rooms filled.

GENERAL SCIENTIFIC SESSIONS

MILWAUKEE AUDITORIUM

Monday, October 7

MORNING

9:00– 9:20 "Management of Dermatitis in General Practice"
STEPHAN EPSTEIN, Marshfield

9:20– 9:40 "Diagnosis of Obscure Fevers in General Practice"
SAMUEL ROSENTHAL, assistant professor of medicine, Marquette University School of Medicine, Milwaukee

9:40–10:00 "Maintenance of Adequate Respiratory Exchange"
RALPH M. WATERS, professor of anesthesia, University of Wisconsin Medical School, Madison

10:00–10:30 RECESS TO VIEW EXHIBITS

10:30–11:00 "Infectious Hepatitis"
M. HERBERT BARKER, assistant professor of medicine, Northwestern University Medical School, Chicago

11:00–11:20 "Treatment of Malaria"
MAURICE HARDGROVE, assistant clinical professor, Marquette University School of Medicine, Milwaukee

11:30–12:00 RECESS TO VIEW EXHIBITS

12:00– 2:00 ROUND-TABLE LUNCHEONS AND DEMONSTRATIONS

AFTERNOON

2:30– 2:50 "General Conception of Rh Factor in the Blood"
WILLIAM D. STOVALL, professor of hygiene, clinical pathologist, University of Wisconsin Medical School, Madison

2:50– 3:10 "The Rh Factor in Obstetrics"
JACK A. KLIEGER, clinical instructor, department of obstetrics and gynecology, Marquette University School of Medicine, Milwaukee

3:10– 3:30 "The Rh Factor in General Practice"
G. P. LANGENFELD, Theresa

3:30– 4:00 RECESS TO VIEW EXHIBITS

4:00– 4:30 "The Diagnosis and Treatment of Common Ano-Rectal Complaints"
J. P. NESSELROD, Evanston

4:30– 5:00 "The Use of Thiouracil and Lugol's Solution in the Preoperative Preparation of the Thyrotoxic Patient"
GEORGE M. CURTIS, professor of surgery, Ohio State University College of Medicine, Columbus

Tuesday, October 8

MORNING

9:00–11:30 SECTION PROGRAMS

(See pages 775–777 for speakers)

11:30–12:00 RECESS TO VIEW EXHIBITS

12:00– 2:00 ROUND-TABLE LUNCHEONS AND DEMONSTRATIONS

AFTERNOON

2:30– 3:00 "The Most Important Therapeutic Measures in the Treatment of Hypertensive Heart Disease"
PAUL D. WHITE, clinical professor of medicine, Harvard Medical School, Boston

3:00– 3:30 "The Treatment of Ununited Fractures by Bone Graft Without Tie or Screw Fixation"
DALLAS B. PHEMISTER, Chicago

3:30– 4:00 RECESS TO VIEW EXHIBITS

(Continued on next page)

4:00– 4:20 **"Hemorrhagic Nephrosis Due to Transfusion Reactions"**

D. MURRAY ANGEVINE, professor of pathology, University of Wisconsin Medical School, Madison

4:20– 4:50 **"The Medical Effects of the Atomic Bomb in Japan"**

A. W. OUGHTERSON, medical and scientific director, American Cancer Society, Inc., New York

Wednesday, October 9

MORNING

9:00– 9:20 **"Antibiotics in Surgery"**

ARTHUR A. SCHAEFER, assistant clinical professor of surgery, Marquette University School of Medicine, Milwaukee

9:20– 9:40 **"Antibiotics in Venereal Disease"**

CAPTAIN L. L. VESEEN, M. C., formerly attending urologist at Passavant Memorial Hospital and Cook County Hospital, Chicago

9:40–10:10 **"Antibiotics"**

WESLEY W. SPINK, professor of medicine, University of Minnesota Medical School, Minneapolis

10:10–10:40 **RECESS TO VIEW EXHIBITS**

10:40–11:10 **"Trench Foot, Immersion Foot and Frostbite"**

H. B. SHUMACKER, JR., assistant professor of surgery, Johns Hopkins University School of Medicine, Baltimore

11:10–11:25 **President's Address**

11:25–11:40 **President-elect's Address**

11:40–12:00 **RECESS TO VIEW EXHIBITS**

12:00– 2:00 **ROUND-TABLE LUNCHEONS AND DEMONSTRATIONS**

AFTERNOON

2:30– 3:00 **"The Physician and Tuberculosis"**

JAY ARTHUR MYERS, professor of medicine, University of Minnesota Medical School, Minneapolis

3:00– 3:30 **"What World War II Has Done for Neuropsychiatry"**

(Theresa Rogers Memorial Lecture)

W. J. BLECKWENN, professor of neuropsychiatry, University of Wisconsin Medical School, Madison

3:30– 4:00 **RECESS TO VIEW EXHIBITS**

4:00– 4:20 **"Burns in Naval Personnel at Okinawa"**

H. W. CHRISTENSEN, Wausau

4:20– 4:40 **"Advances in the Diagnosis and Treatment of Some Pediatric Conditions"**

F. R. JANNEY, professor of pediatrics, Marquette University School of Medicine, Milwaukee

4:40– 5:00 **"Protrusion of the Intervertebral Disc"**

THEODORE C. ERICKSON, associate professor of surgery (neurosurgery), University of Wisconsin Medical School, Madison

J. P. GREENHILL

OBSTETRICAL DEMONSTRATIONS SCHEDULED

Each day, following luncheon in the Pere Marquette Room, Hotel Schroeder, an obstetrical Manikin demonstration will be held, with attendance limited to 40. On Monday and Tuesday "repeat demonstrations" at 4:30 p. m.

See the September *Journal* for further details and pictures of all three demonstrators.

Monday, Oct. 7	Tuesday, Oct. 8	Wednesday, Oct. 9
J. P. GREENHILL *Chicago*	J. E. FITZGERALD *Chicago*	CARLTON WIRTHWEIN *Milwaukee*

Demonstrations arranged by Drs. Henry J. Olson and Benjamin E. Urdan, Milwaukee.

SECTION SCIENTIFIC SESSIONS

105th ANNUAL MEETING
MILWAUKEE, OCTOBER 7-8-9
STATE MEDICAL SOCIETY of Wisconsin

HOSPITAL RELATIONS

Russell M. Kurten, Chairman, Racine — Engelmann Hall

Tuesday, October 8

9:00– 9:20 "Visual Education for the Public in Hospital Public Rooms"
ARNOLD S. JACKSON, attending surgeon, Methodist Hospital, Madison

9:20– 9:40 "The Integrated Laboratory"
MR. JOSEPH NORBY, administrator, Columbia Hospital, Milwaukee

9:40–10:00 "Hospital Postgraduate Education"
OVID O. MEYER, professor of medicine, University of Wisconsin Medical School, Madison

10:00–10:30 RECESS TO VIEW EXHIBITS

10:30–10:45 "The Impact of Hospital and Prepaid Surgical and Obstetrical Insurance on the Private Hospital"
REV. W. G. SODT, administrator, Milwaukee Hospital, Milwaukee

10:45–11:00 "The Public in the Nursing Problem"
SISTER M. AUGUSTA, dean, College of Nursing, St. Joseph's Hospital, Milwaukee

11:00–11:30 "Today's Health Problems for Farmers"
K. A. KIRKPATRICK, Director of Hospital Service, Minnesota Farm Bureau Federation, St. Paul

HOSPITAL RELATIONS LUNCHEON, Tuesday, October 8, Hotel Schroeder:

Doctor Kurten has arranged to have Colonel J. C. Harding of the Veterans' Administration, Washington, D. C., as guest speaker. Doctor Harding is Assistant Medical Director, serving under General Hawley. The title of Colonel Harding's address at the Hospital Relations Luncheon will be "The Care of the Veteran—Present and Future."

INTERNAL MEDICINE

Chester Kurtz, Chairman, Madison — Plankinton Hall

Tuesday, October 8

9:00– 9:20 "Diphtheritic Heart Disease"
MISCHA J. LUSTOK, Milwaukee

9:20– 9:30 Discussion
WILLIAM S. MIDDLETON, dean, and professor of medicine, University of Wisconsin Medical School, Madison

9:30–10:00 "Use of Folic Acid in Treatment of Macrocytic Anemias"
CARL V. MOORE, professor of medicine, Washington University School of Medicine, St. Louis

10:00–10:30 RECESS TO VIEW EXHIBITS

10:30–11:00 "New Methods for the Control of Acute Respiratory Infections"
O. H. ROBERTSON, professor of medicine, University of Chicago, The School of Medicine, Chicago

11:00–11:30 "The Low Sodium Diet in Congestive Heart Failure"
PAUL D. WHITE, clinical professor of medicine, Harvard Medical School, Boston

OBSTETRICS & GYNECOLOGY

Benjamin E. Urdan, Chairman, Milwaukee — South Juneau Hall

Tuesday, October 8

9:00– 9:20 "A Five-Year Survey (1941–1945) of Obstetrics at St. Joseph's Hospital"
H. J. OLSON, associate professor of obstetrics and gynecology, Marquette University School of Medicine, Milwaukee

9:20– 9:30 Discussion E. F. SCHNEIDERS, Madison

9:30– 9:50 "Skin Manifestations of Menstruation" KURT WIENER, Milwaukee

9:50–10:00 Discussion
G. A. COOPER, instructor in dermatology, University of Wisconsin Medical School, Madison

10:00–10:30 RECESS TO VIEW EXHIBITS

10:30–10:50 "Ectopic Pregnancy"
MADELINE J. THORNTON, associate professor of obstetrics and gynecology, University of Wisconsin Medical School, Madison

10:50–11:00 Discussion
R. S. CRON, head of department of obstetrics and gynecology, Milwaukee University School of Medicine, Milwaukee

11:00–11:30 "Gynecologic Endocrinology in General Practice"
J. P. GREENHILL, professor of gynecology, Cook County Graduate School of Medicine, Chicago

OPTHALMOLOGY & OTOLARYNGOLOGY

F. H. Haessler, Chairman, Milwaukee — North Juneau Hall

Tuesday, October 8

9:00– 9:20 "Some Primary Considerations in Retinal Detachment"
PETER A. DUEHR, assistant professor of ophthalmology, University of Wisconsin Medical School, Madison

9:20– 9:30 Discussion
REINHOLD EBERT, Oshkosh

9:30–10:00 "Ocular Tuberculosis"
FRANK N. KNAPP, Duluth, Minnesota

10:00–10:30 RECESS TO VIEW EXHIBITS

10:30–10:50 "The Importance of Adequate Nasal Ventilation"
FRANK TRESKOW, Milwaukee

10:50–11:00 Discussion
T. L. TOLAN, Milwaukee

11:00–11:30 "Malignant Tumors of the Pharynx and Larynx"
FREDERICK A. FIGI, associate professor laryngology, oral and plastic surgery, Mayo Foundation, University of Minnesota Graduate School

PEDIATRICS

John E. Gonce, Jr., Chairman, Madison — North Kilbourn Hall

Tuesday, October 8

9:00– 9:20 "Recent Advances in Immunization Procedures"
R. P. SCHOWALTER, assistant clinical professor, Marquette University School of Medicine, Milwaukee

9:20– 9:30 Discussion
L. M. SIMONSON, Sheboygan

(Continued opposite page) ——→

105th ANNUAL MEETING
MILWAUKEE, OCTOBER 7-8-9
STATE MEDICAL SOCIETY of Wisconsin

RADIOLOGY

E. A. Pohle, Chairman, Madison — Walker Hall

Tuesday, October 8

9:00– 9:20 "Lesions of the Lungs and Heart"
RUSSELL F. WILSON, Beloit

9:20– 9:40 "Technic in Gallbladder, Stomach and Colon Examinations"
C. F. SHERMAN, Madison

9:40–10:00 "Radiographic Examination of the Urinary Tract"
RALPH L. TROUP, Green Bay

10:00–10:30 RECESS TO VIEW EXHIBITS

10:30–10:50 "Fundamental Principles of Radiation Therapy"
E. A. POHLE, professor of radiology, University of Wisconsin Medical School, Madison, and ELIZABETH CLARK, instructor in radiology, University of Wisconsin Medical School, Madison

10:50–11:10 "Bone and Joint Conditions Other Than Fractures"
S. A. MORTON, professor of radiology, Marquette University School of Medicine, Milwaukee

11:10–11:30 "Fractures, Wrist and Ankle"
L. V. LITTIG, Madison

SURGERY

Anthony R. Curreri, Chairman, Madison — South Kilbourn Hall

Tuesday, October 8

9:00– 9:20 "Present Status in the Treatment of Perforated Appendix"
C. F. CONROY, Milwaukee

9:20– 9:30 Discussion

9:30– 9:50 "Fracture Disabilities"
M. L. JONES, Wausau

9:50–10:00 Discussion
T. D. SMITH, Neenah

10:00–10:30 RECESS TO VIEW EXHIBITS

10:30–10:50 "Fundamental Principles in the Treatment of Traumatic Wounds"
FORRESTER RAINE, associate clinical professor of surgery, Marquette University School of Medicine, Milwaukee

10:50–11:00 Discussion
J. W. MCROBERTS, Sheboygan

11:00–11:30 "Surgery of the Spleen"
GEORGE M. CURTIS, professor of surgery, Ohio State University College of Medicine, Columbus

PEDIATRICS (con't)

9:30–10:00 "Allowing Young Children to Do Their Stuff"
C. ANDERSON ALDRICH, professor of pediatrics, Mayo Foundation, Graduate School, University of Minnesota

10:00–10:30 RECESS TO VIEW EXHIBITS

10:30–10:50 "Treatment of Meningitis"
KENNETH B. MCDONOUGH, assistant professor of pediatrics, University of Wisconsin Medical School, Madison

10:50–11:00 Discussion
F. R. JANNEY, professor of pediatrics, Marquette University School of Medicine, Milwaukee

11:00–11:30 "The Use of Antibiotics in Pediatrics"
ROGER L. J. KENNEDY, associate professor of pediatrics, Mayo Foundation, University of Minnesota Graduate School

105th ANNUAL MEETING
MILWAUKEE, OCTOBER 7-8-9
STATE MEDICAL SOCIETY of Wisconsin

SPECIAL PROGRAM FEATURES

■ **DEMONSTRATIONS EXPANDED:** Recognizing the value of clinical demonstrations, and at the same time the necessity of keeping instructional groups small to enhance the teaching value of the demonstration, the Council on Scientific Work asked Doctor Schmidt to provide one outstanding demonstration to be held in connection with the noon luncheons each day, in addition to the Obstetrical Manikin Demonstrations which have proved such popular features of the Annual Meetings in 1942–43–44.

In response to this request Doctor Schmidt has provided the following schedule of Clinical Demonstrations. In each case the demonstration will follow luncheon, and *attendance will be limited to 40 persons.*

MONDAY, OCTOBER 7: *Cardiac Diagnosis:* DR. CHESTER M. KURTZ, associate professor of medicine, University of Wisconsin Medical School, Madison.

TUESDAY, OCTOBER 8: *Disc Syndrome and its Diagnosis:* DR. THEODORE C. ERICKSON, associate professor of surgery (neurosurgery), University of Wisconsin Medical School; and Dr. L. W. Paul, associate professor of radiology, University of Wisconsin Medical School, Madison.

WEDNESDAY, OCTOBER 9: *Diagnosis and Treatment of Allergic Diseases:* DR. T. L. SQUIER, associate clinical professor of medicine, Marquette University School of Medicine, Milwaukee.

■ **OB MANIKIN DEMONSTRATIONS REPEATED:** In 1944 the Obstetrical Manikin Teaching Demonstrations were presented in connection with the noon luncheon program, *with attendance limited to 40 participants.* This plan proved so successful that it will be repeated again this year. Dr. Henry J. Olson, Milwaukee, is assisting the Council by making arrangements for these demonstrations. Teachers for all three days will be announced in the September *Journal,* which will carry a full listing of round-table luncheons.

In order to accommodate those who are unable to attend the noon Obstetrical Manikin Demonstration, provision is being made to have the noon teaching program repeated between 4:30 and 5:30 p. m.

All of the Manikin Demonstrations will be held in the Pere Marquette Room of the Hotel Schroeder.

■ **GOLF TOURNAMENT REVIVED:** The Physicians Golf Tournament will be held during the Annual Meeting again this year, after a "wartime recess." Tournament arrangements are being made by Dr. G. R. Love, Oconomowoc, and will be announced in the September *Journal.*

H. H. SHOULDERS

■ **AMA PRESIDENT WILL SPEAK AT ANNUAL DINNER:** President P. R. Minahan is pleased to announce that the featured speaker of the evening program Tuesday, following the annual dinner, will be Dr. Harrison H. Shoulders, Nashville, Tennessee, president of the American Medical Association. Doctor Shoulders is a forceful speaker, and will contribute much to the success of the dinner program. In connection with the annual dinner, attention is called to the fact that the Hotel Schroeder has found it necessary to limit the number served. In order to avoid disappointment it is urged that all members desirous of participating in the Tuesday evening meeting send in their space reservations as soon as reservation slips for luncheons and dinner have been distributed.

Following the custom of other years, the Tuesday evening meeting will be open to wives and guests of physician members. Auxiliary social functions will have been completed by Tuesday evening, so wives may attend the Annual Banquet with their husbands.

■ **SPECIAL FEATURES FOR VETERANS:** During the Annual Meeting several special features have been planned for members returning from the armed services. The Informal Smoker, which has been presented in the Crystal Ballroom the opening night of the meeting, will be replaced by a special reception and evening of entertainment for returning service members, presented by the State Medical Society. Special invitations will be extended to all veteran members giving them details of the program.

In addition to the Monday evening program for veterans, tentative plans are being made for a special luncheon Tuesday noon, open to all members who served in World War II.

■ **MEDICAL MOTION PICTURE THEATRE TO REPEAT:** In 1944, a full two hours of medical motion pictures were shown in a room close to Plankinton Hall, during both the morning and afternoon scientific sessions. This gave everyone an opportunity of viewing the pictures selected for the Council on Scientific Work by Dr. H. Kent Tenney, Madison.

Several outstanding pictures shown at the recent A. M. A. meeting are yet to be reviewed, but to date the following pictures have been selected for projection:

Abnormalities in Gait. This picture, part of a series produced under the title *Physical Diagnosis*, and distributed through the American Medical Association, portrays the following types of gait: Tabes dorsalis showing ataxic gait, romberg, sign, charcot joint; cerebellar ataxia; spastic paraplegia (showing scissor gait, spastic gait, hyperactive tendon reflexes, ankle clonus, and positive babinski); hemiplegic gait; steppage gait with foot-drop; gait in poliomyelitis; list in a case of sciatic neuralgia; gait in ankylosis of hip and spine; pseudohypertrophic muscular dystrophy; gait of dystonia musculorum deformans; and characteristics of Parkinson's disease.

Repair of Congenital Tracheo-Esophageal Fistula With Atresia: Dr. Conrad R. Lam, Detroit, Michigan. The film consists of a pictorial case history of an infant born with atresia of the esophagus and tracheo-esophageal fistula. The chief points in the establishment of the diagnosis are outlined. Operation in this case was carried out on the fifth day of life. The preferred operation of ligation of the fistula and direct anastomosis of the segments of the esophagus within the mediastinum was carried out. The operation is demonstrated by views of the actual procedure and explanatory diagrams. Postoperative care and outpatient followup are depicted.

Accent on Use: National Foundation for Infantile Paralysis, Inc. This film was prepared to show the various technics of physical therapy used in the treatment of poliomyelitis. While much of the material is of common knowledge to members of the profession who have directed their attention to this particular medical problem, the film will serve as a good review of methods which might be employed effectively in any hospital in Wisconsin.

Proctoscopic Cinematography: Drs. J. P. Nesselrod, Evanston, Ill., and Jay M. Garner, Winnetka, Ill. This film begins with the technic of introducing the proctoscope and then shows the appearance of the sigmoid, rectum, and anal canal as seen through the sigmoidoscope. The normal bowel is followed by views of diverticulitis, lymphogranuloma venereum, tuberculous enterocolitis, ulcerative colitis, sigmoidal polyps with fulguration and views during the various stages of healing, recticulum cell lymphosarcoma of the bowel, carcinoma of the bowel, and the appearance of the sigmoid and rectum after a barium enema.

Early Ambulation After Operation and Related Procedures: Dr. D. J. Leithauser, Detroit, Michigan. The film presents the principal factors involved in postoperative morbidity. Noxious reflexes to vital organs from the area of trauma are shown by animation. Patients are presented getting out of bed shortly after abdominal operations and their activity gradually increased. control of pulmonary complications by coughing in the standing position is presented. The rapid convalescence after operation is readily recognized.

■ **WIDE VARIETY ON SCIENTIFIC EXHIBITS:** Dr. C. D. Neidhold, Appleton, chairman of the Council on Scientific Work, has completed arrangements for the scientific exhibits at the 1946 Annual Meeting. The September issue of the *Journal* will carry a detailed description of the technical exhibits as well as those devoted to scientific subjects. Following are listed the scientific exhibits which will be featured in October:

Booth No.	
S–8, S–9	**Council on Physical Medicine of the American Medical Association:** This exhibit will feature lip reading demonstrations and the latest types of hearing aids approved by the Council on Physical Medicine
S–10	**"Determination of Prothrombin":** Armand J. Quick, M. D., professor of biochemistry, Marquette University School of Medicine
S–11	**"Endocrine Products: Action and Uses":** American Medical Association
S–12	**"Malaria":** American Medical Association
S–13	**"Food Poisoning and Food Borne Infections":** American Medical Association
S–14	**"Cancer Detection in General Practice":** American Cancer Society
S–15	**"Early Diagnosis and Treatment of Rheumatoid Arthritis of the Spine":** Wisconsin Rheumatism Association
S–16, S–17	**"Early Diagnosis of Cervical Carcinoma":** Charles E. Galloway, M. D., Evanston, Illinois
S–18, S–19, S–20	**Section on Radiology:** Interesting case studies with explanations by attendant radiologists. Also, papers will be presented at each recess time, covering various phases of radiologic studies
S–21	**"Studies on Thiouracil":** S. B. Barker, Ph. D., assistant professor, department of physiology, University of Iowa College of Medicine
S–22	**Curative Workshop of Milwaukee:** The exhibit will feature motion pictures describing the physical and occupational therapy treatments employed at the Curative Workshop
S–23, S–24	**"The Management of Respiratory Difficulties":** Ralph M. Waters, M. D., professor of anesthesia, University of Wisconsin Medical School
S–25, S–26	**Wisconsin Anti-Tuberculosis Association:** An exhibit showing the incidence of tuberculosis and modern methods of treatment
S–27, S–28	**"Intervertebral Disc Herniation":** Jackson Clinic, Madison, Arthur C. Stirling, M. D. The exhibit is prepared with special reference to the protruding nucleus pulposus in the lumbar region giving the causes, symptoms, diagnostic tests, and the methods of treatment; conservative and surgical
S–29	**Wisconsin Pharmaceutical:** Subject to be announced
S–30, S–31, S–32	**Applied Anatomy:** Presented by the anatomy departments of Marquette University School of Medicine and the University of Wisconsin Medical School. Actual dissections will be presented by instructors from both teaching institutions

Booth No.

S–33, S–34 **Mayo Foundation, University of Minnesota Graduate School:** "Accidents on the Farm and How They Happen"

S–35 **State Board of Health:** "X-rays for Hospital Admissions"

Lounge **Rh Factor:** W. D. Stovall, M. D., director of State Laboratory of Hygiene.

" **Wisconsin Heart Association:** Subject to be announced.

" **Wisconsin Medicine of the Past:** State Historical Society of Wisconsin. This exhibit will feature old instruments, record books, texts, and other material housed in the archives of the State Historical Museum, which it is felt will be of great interest to physicians of the present.

■ **RECORD NUMBER OF TECHNICAL EXHIBITS:** The demand for exhibit space in connection with the Annual Meeting has been unusually heavy. Within two hours after reservations were accepted, the entire number of booths allotted for technical exhibits had been sold. As usual the exhibitors will feature new products offered to the profession, and in many cases special demonstrations will be held during the recess periods provided for the specific purpose of viewing the technical exhibits in the Main Arena of the Milwaukee Auditorium.

The exhibit hall will be open from 8:00 a. m. to 5:30 p. m.

The list of 1946 technical exhibitors follows:

COMMERCIAL EXHIBITS

Booth Number	Exhibitor
35	Abbott Laboratories, North Chicago, Ill.
20	A. S. Aloe Company, St. Louis, Mo.
51	American Hospital Supply Corporation, Chicago, Ill.
6	Ames Company, Incorporated, Elkhart, Ind.
S–6 S–7	Armour Laboratories, Chicago, Ill.
48	Ayerst, McKenna & Harrison, New York, N. Y.
14	Barr X-Ray Company, Milwaukee, Wis.
43	Benson Optical Company, Inc., Minneapolis, Minn.
13	Bidwell Better Limbs, Milwaukee, Wis.
52	Bilhuber–Knoll Corporation, Orange, N. J.
S–40	Blakiston Company, Philadelphia, Pa.
39	Borden Company, New York, N. Y.
15	Brooks Appliance Company, Chicago, Ill.
40	Burroughs Wellcome and Company, New York, N. Y.
25–26	Camel Cigarettes, New York, N. Y.
S–1	Cameron Surgical Specialty Company, Chicago, Ill.
37	S. H. Camp & Company, Jackson, Mich.
67	Carnation Company, Oconomowoc, Wis.
63	Ciba Pharmaceutical Products, Inc., Summit, N. J.
17	Coca-Cola Company, Milwaukee, Wis.
68	Depuy Manufacturing Company, Warsaw, Ind.
5	DeVilbiss Company, Toledo, O.
32	H. G. Fischer & Company, Chicago, Ill.
1	General Electric X-Ray Corp., Chicago, Ill.
41	Gerber Products Company, Fremont, Mich.
11	Grune and Stratton, Inc., New York, N. Y.
66	Chr. Hansen's Laboratory, Inc., Little Falls, N. Y.
S–5	H. J. Heinz Company, Pittsburgh, Penn.
S–37	Hoffmann–LaRoche, Inc., Nutley, N. J.
38	Hurley X-Ray Company, Milwaukee, Wis.
22	E. H. Karrer Company, Milwaukee, Wis.
50	Kelley–Koett Manufacturing Co., Covington, Ky.
23–24	Lakeside Laboratories, Inc., Milwaukee, Wis.
S–38	Lea and Febiger, Philadelphia, Pa.
16	Lederle Laboratories, Inc., New York, N. Y.
34	Libby, McNeill and Libby, Chicago, Ill.
42	Eli Lilly and Company, Indianapolis, Ind.
18	J. B. Lippincott Company, Philadelphia, Pa.
46	M & R Dietetic Laboratories, Inc., Columbus, O.
21	Maltine Company, New York, N. Y.
27	Mead Johnson and Company, Evansville, Ind.
S–2	Medical Protective Company, Fort Wayne, Ind.
29–30	Medico–Mart, Incorporated, Milwaukee, Wis.
45	Mellin's Food Co., Boston, Mass.
61	Mennen Company, Newark, N. J.
64	Wm. S. Merrell Company, The, Cincinnati, O.
3	Philip Morris and Company, Ltd., New York, N. Y.
65	C. V. Mosby Company, St. Louis, Mo.
44	V. Mueller and Company, Chicago, Ill.
28	National Live Stock and Meat Bd., Chicago, Ill.
S–4	Ohio Chemical & Mfg. Co., Chicago, Ill.
56	Parke, Davis and Company, Detroit, Mich.
S–42	Downs X-Ray Company, Milwaukee, Wis.
12	Pengelly X-Ray Company, Milwaukee, Wis.
54–55	Pet Milk Sales Corporation, St. Louis, Mo.
57–58	Physicians and Hospitals Supply Co., Inc., Minneapolis, Minn.
69	Pitman – Moore Company, Indianapolis. Ind.
8	Procter and Gamble Co., Ivorydale, O.
53	Roemer Drug Company, Milwaukee, Wis.
S–39	Sandoz Chemical Works, Inc., New York, N. Y.
60	W. B. Saunders Company, Philadelphia, Pa.

Booth Number	Exhibitor
33	Schenley Laboratories, Inc., New York, N. Y.
9	Schering Corporation, Bloomfield, N. J.
10	G. D. Searle and Company, Chicago, Ill.
19	Sharp and Dohme, Inc., Philadelphia, Pa.
S–41	Smith–Dorsey Company, Lincoln, Neb.
31	Smith, Kline and French Laboratories, Philadelphia, Pa.
4	Spencer, Inc., New Haven, Conn.
7	E. R. Squibb and Sons, New York, N. Y.
S–36	Frederick Stearns and Company, Detroit, Mich.
59	Ulmer Pharmacal Company, Minneapolis, Minn.
49	A. R. Nechin Co., Chicago, Ill.
62	U. S. Standard Products Co., Woodworth, Wis.
2	White Laboratories, Incorporated, Newark, N. J.
36	Winthrop Chemical Company, Inc., New York, N. Y.
S–3	Wright's Incorporated, Milwaukee, Wis.
47	Zimmer Manufacturing Company, Warsaw, Indiana.

AMERICAN COLLEGE OF CHEST PHYSICIANS ANNUAL MEETING

Milwaukee, October 6

Preceding the State Medical Society's 105th Annual Meeting, the American College of Chest Physicians, Wisconsin Chapter, will hold its second annual meeting at the Hotel Schroeder, Milwaukee, Sunday, October 6. The scheduled program of the day's events follows:

2:00 p.m. Scientific Session—Leonard W. Moody, M. D., F. C. C. P., Bayfield, Wis., presiding.

1. "Diagnosis in Puzzling Lung Conditions." Illustrated with 75 lantern slides.
   H. I. Spector, M. D., F. C. C. P., associate professor of medicine, St. Louis University, St. Louis, Mo.
   Discussant:
   Mischa J. Lustok, M. D., F. C. C. P., Milwaukee.
2. "Loeffler's Syndrome."
   Theodore L. Squire, M. D., F. A. C. P., associate clinical professor of medicine. Marquette University School of Medicine, Milwaukee.
   Discussants:
   J. J. Mendelsohn, M. D., F. C. C. P., professor of medicine, Loyola University School of Medicine, Chicago.
   George H. Jurgens, M. D., F. C. C. P., Milwaukee.
3. "Histoplasmosis and Allied Lung Conditions."
   Herbert L. Mantz, M. D., F. C. C. P., tuberculosis controller, Kansas City, divisional chief, Tuberculosis Service, Veterans Administration, Kansas City, Mo.
   Discussants:
   Arthur S. Webb, M. D., F. C. C. P., F. A. C. P., tuberculosis controller, Du Page County, Illinois, Glen Ellyn, Ill.
   Gerald Guilbert, M. D., F. C. C. P., chief of tuberculosis division, U. S. Veterans Hospital, Wood, Wis.
4. "The Roentgen Diagnosis of Tumors of The Lung."
   Leo G. Rigler, M. D., professor of roentgenology, University of Minnesota Medical School, Minneapolis, Minn.
   Discussants:
   Irving I. Cowan, M. D., roentgenologist to Mount Sinai Hospital, Milwaukee.
   Harry Barell, M. D., Waukesha, Wis.
5. "Manifestations and Modern Management of Pulmonary Suppuration."
   Paul H. Holinger, M. D., F. C. C. P., assistant professor of laryngology, University of Illinois College of Medicine, Chicago.
   Discussant:
   Leon H. Hirsh, M. D., F. C. C. P , Milwaukee.

6:00 p. m. Dinner Meeting—Carl O. Schaefer, M. D., F. A. C. S., F. C. C. P., Racine, Wis., presiding.

1. "Psychosomatic Medicine and Tuberculosis."
   Charles M. Hendricks, M. D., F. C. C. P., president, American College of Chest Physicians, El Paso, Texas.

8:00 p. m. X-Ray Conference—Etan B. Pfefferkorn, M. D., F. C. C. P., Oshkosh, Wis., presiding.
X-ray films of unusual interest will be shown at this conference.

As It Looks to Your State Board of Health

(These timely discussions of health problems are prepared by staff members as a special service to Wisconsin's physicians.)

Rh Typing Service Available

The discovery of the erythrocytic antigen, Rh, and its specific antibody has added another antigen-antibody complex associated with the hemolysis of erythrocytes, and has afforded an explanation of many unexplained blood transfusion reactions and most of the cases of erythroblastosis.

The hemolysis produced in the child during the last months of pregnancy takes place by an exchange of the antigen, Rh, from the child to the blood stream of the Rh negative mother who as a result develops antibodies which pass through the placenta into the blood stream of the child. In the child's blood stream the antibody becomes attached to the Rh antigen of the erythrocytes and destroys these cells. The result of this destruction is an increased activity of the erythropoietic tissue in an attempt to replace the destroyed red cells, and the development of erythroblastosis.

The intensity of the reaction depends upon the amount of the antibody produced by the mother and the amount that reaches the blood stream of the child. In severe cases hydrops fetalis or icterus neonatorum gravis occurs while in the less severe reactions the child is born in apparent health or with a slight icteric tint. In either of the latter instances the child may begin to show a deepening icterus a few hours, days, or weeks after birth. Some of these babies recover without treatment but in many cases that have not been treated, red cell destruction becomes so great that the child dies, sometimes within a few hours.

To offer erythroblastotic babies a chance to live it is necessary that they be transfused with compatible Rh negative blood. If blood, the cells of which belong to the same group as that of the child and are Rh negative, is available, it is the blood of choice. However, if such blood can not be procured or is not readily available, group O, Rh negative blood must be used; neither the whole blood of the mother nor the father is suitable. A transfusion of 75 cc. of group O Rh negative blood and a repetition of this amount twelve to twenty-four hours later is sufficient to carry the child through a hemolytic reaction even though all of his own cells are destroyed. The transfused cells remain in the blood stream for approximately ninety days and by that time the erythropoietic system has produced an adequate supply of cells.

It has been estimated that 12 per cent of all marriages take place between Rh negative women and Rh positive men. This is the mating essential for the occurrence of erythroblastosis in all but a few exceptional cases. Fortunately, many women never develop Rh antibodies and therefore never have their child bearing period interrupted by the development of sensitivity to the Rh factor. Another large per cent do not produce these antibodies until several, two or more, healthy children are born. However, the best medical management can be affected only when the Rh factor of both the wife and husband is known, particularly in those cases where there is a history of the loss of a child close to or at term, or several days after birth. In the later cases it is helpful to test for the development of Rh antibodies during the last two or three months of the pregnancy. The test for these antibodies is often interfered with by inhibiting antibodies and therefore a special technic must be employed.

The State Laboratory of Hygiene has been able to develop a supply of anti-Rh serum for typing Rh blood and in the near future will be able to supply all hospitals in the state with it. The central laboratory, the branch laboratory, and all cooperative laboratories are prepared to do typing for the Rh factor and testing for antibodies for physicians who do not have available this service in their own communities. With this service available, physicians will be able to predict the occurrence of erythroblastosis and be prepared with suitable blood for the transfusion of these infants.—W. D. Stovall, M. D., *Director, State Laboratory of Hygiene.*

Looking at Sickness Insurance Abroad

By J. G. CROWNHART

Just prior to his death in Cleveland in 1941, J. G. Crownhart, Secretary of the State Medical Society of Wisconsin, addressed the Health and Accident Underwriters Conference in Chicago on "Looking at Sickness Insurance Abroad." With the current hearings and discussion on the Wagner-Murray-Dingell legislation and the whole subject of compulsory sickness insurance, it seems again timely to present Mr. Crownhart's paper in The Wisconsin Medical Journal. For the convenience of the reader, the whole paper was published in the July, 1941, issue of the Journal. It will be reprinted in installments in current issues of the Journal of 1946, beginning with the June issue and continuing through the October issue.

PART III

The Man Who Pays

(Continued from the July Journal)

THE recipient of benefits under compulsory sickness insurance knows exactly what he is going to receive in terms of cash for his wage loss benefits when these are a part of the system as is so universally the case. This is not the case of his medical *service* benefits. To the extent that the amount of money required to pay wage loss has been underestimated in establishing the initial premium, to that same extent must the sickness insurance fund divert money from sickness care to defray wage loss claims. The cash benefits always must have precedence, for the worker knows at once if the cash benefit promised him is not paid or is paid in a lesser amount than that promised. Not so with the sickness care that is promised. Here the administrator finds the opportunity to balance his budget,—and may I parenthetically remark that the administrator who does not balance his budget will not long remain the administrator. In the field of the sickness care service benefits, the administrator may subtract from the service benefits promised and the recipient sick person may never know that such subtraction has taken place. Nor, as I pointed out earlier, is there any penalty upon the system for cheapening the sickness care rendered to the subscriber. On the contrary, the reward is the balanced budget that insures continuance of the administrative personnel.

Just as the insurance company with a heavy risk that involves more than the normal uncertainties turns to reinsurance, so out of absolute necessity does each of the compulsory sickness insurance systems reinsure, in as large part as possible, the risks that it undertakes in guaranteeing its medical service benefits. The physician becomes the actual insurer of service, for the administrator turns to him and says, in effect, "Henceforth this system of compulsory sickness insurance will supply the medical care that large numbers of patients formerly received from you. Do you wish to be a part of this system?"

Obviously, numbers of physicians, and particularly those who live in the industrial areas, can ill afford to say, "No," to such a question. And it is then that they become the real insurers for the system says to the physicians, "Very well, then, for each person that we cover who chooses you as his family physician when he enters the system, we will pay you so many dollars per year." For this flat amount ($2.25 per year per individual in the English system, for instance) the physician undertakes to render the care that the terms of the law provide he shall render.

Rules For the Patient

Note, incidentally, that the covered person who becomes ill does not call his physician tonight on the basis of his particular illness needs. He must make his selection when he becomes insured. His selection must be from those physicians who live close to him. If the income of the service permits any specialist service, which is always contemplated but rarely exists, he may go to the specialist solely by reference and then only when the rules and regulations permit. Does he wish to change his physician? Then he must wait until the next change-over period. Nor may he change for reasons that are deemed to be frivolous.

This is not a system which supplies the cash with which the patient may secure his own sickness needs under contracts into which he himself enters. There are rules for patients and the first one deprives him of choosing his physician at the time of his illness. I read to you some other rules for patients, and here I quote from the English system:

"(a) He shall, when applying to a practitioner for treatment, produce his medical card, if required by the practitioner to do so;

"(b) He shall obey the instructions of the practitioner attending him;

"(c) He shall not conduct himself in a manner which is likely to retard his recovery;

"(d) He shall not make unreasonable demands upon the professional services of the practitioner attending him;

"(e) He shall, whenever his condition permits, attend at the surgery or place of residence of the practitioner attending him on such days and at such hours as may be appointed by the practitioner;

"(f) He shall not summon the practitioner to visit him between the hours of 6 p. m. and 10 a. m. except in cases of serious emergency;

"(g) He shall, when his condition requires a home visit, give notice to the practitioner, if the circumstances of the case permit, before 10 a. m. on the day on which the visit is required.

"The rules of the Committee also provide that any complaint by an insured person which is adjudged by them to be frivolous or vexatious, shall be regarded as a breach of their Rules.

"Any insured person who is guilty of a breach of any of the Committee's rules is liable to a fine not exceeding 10/– or in the case of repeated breaches 20/–, or to be suspended from Medical Benefit for a period not exceeding one year.

"These Rules are liable to alteration, due notice of which will be given in the public Press."

(To be continued)

RECENT WISCONSIN LICENTIATES

At a meeting held in Madison on April 13, the Wisconsin State Board of Medical Examiners licensed through reciprocity the following physicians in the practice of medicine after they had successfully passed an examination.

Name	*School of Graduation*	*Year*	*Address*
Beamer, George D.	Indiana	1929	259 East Wells Street, Milwaukee
Clark, Eugene Vincent, Jr.	Arkansas	1940	276 Linden Street, Fond du Lac
Clark, Ivan T.	Ohio	1941	824 Medical Arts Building, Duluth, Minnesota
Crumpton, Charles W.	Tulane	1942	1300 University Avenue, Madison
Culmer, Ausmon E., Jr.	Oklahoma	1940	1300 University Avenue, Madison
Cunningham, Ralph T.	Nebraska	1937	172 Monroe Park, Madison
Dasler, Herbert A.	Wisconsin	1944	116 Lathrop Street, Madison
Dibble, Howard C.	Chicago	1942	217 West Howard Street, Portage
Eickhoff, Everett C.	Louisville	1943	300 Edison Street, Antigo
Ender, Carl A.	Wisconsin	1941	Viroqua
Glickman, Leo G.	Illinois	1925	1359 Main Street, Marinette
Hawk, Malcolm H.	Jefferson	1934	1300 University Avenue, Madison
Kantor, Samuel	Illinois	1938	509 St. Lawrence Avenue, Beloit
Killins, Jack A.	Nebraska	1937	306 Cherry Street, Green Bay
Lehmer, Robert A.	Nebraska	1943	Colby
Pastron, Seymour E.	Illinois	1940	2629 North Forty-ninth Street, Milwaukee
Reiner, Walter M.	Nebraska	1941	609 Garfield, Holdrege, Nebraska
Riegel, Gordon S.	Minnesota	1943	St. Croix Falls
Roemer, Edward P.	Cornell	1934	1 West Main Street, Madison
Rosenstiel, Henry C.	Illinois	1935	Sheboygan Clinic, Sheboygan
Stoddard, Frederick J.	Pennsylvania	1939	2914 North Summit Avenue, Milwaukee
Stovall, William D., Jr.	Wisconsin	1944	205 Princeton Avenue, Madison
Tandy, Roy W., Sr.	Washington	1930	Washburn
Tausend, Harold J.	Texas	1941	1300 University Avenue, Madison
Vanstane, Virgil R.	Rush	1926	4753 North Broadway, Chicago, Illinois
Weller, Lewis J.	Northwestern	1941	Osceola

The following physicians were granted licenses through reciprocity in Madison on May 21.

Name	*School of Graduation*	*Year*	*Address*
Bailey, Donald M.	Hahnemann	1941	P. O. Building, Gillett
Baldigo, Edward M.	Minnesota	1940	3934 North Stowell Avenue, Milwaukee
Bidford, Walter D.	Marquette	1943	229 West New York Avenue, Oshkosh
Bookhamer, James W.	Marquette	1941	3912 West Roberts Street, Milwaukee
Brusky, Symphorian F.	Marquette	1944	Pulaski
Crikelair, George F.	Wisconsin	1944	1125 South Jackson Street, Green Bay
Greenwalt, Tibor J.	New York	1937	536 West Wisconsin Avenue, Milwaukee
Grundahl, Alvin T.	Iowa	1943	730 South Sixth Street, West Bend

Name	School of Graduation	Year	Address
Johnson, Allen G.	Minnesota	1939	1707 West Twenty-sixth Street, Minneapolis, Minnesota
Markey, Francis L.	Marquette	1944	2252 South Hamilton Street, Saginaw, Mich.
Mathwig, Robert J.	Louisville	1942	712 South Park Avenue, Oshkosh
Matthiesen, Don E.	Temple	1944	Dodgeville
Meeter, Urquhart L.	Iowa	1940	Medford
Nuebel, Charles J.	Minnesota	1937	Hudson
Richtsmeier, Anthony J.	Iowa	1943	1300 University Avenue, Madison
Santina, Henry	Marquette	1944	316 South State Street, Waupaca
Simpson, Ronald A.	Kansas	1940	1300 University Avenue, Madison
Twyman, Allen H.	Indiana	1942	Beloit Municipal Hospital, Beloit
Vaudreuil, William F.	Wisconsin	1940	First National Bank Building, Rice Lake
Weissman, Irving	Illinois	1939	1300 University Avenue, Madison

The Wisconsin State Board of Medical Examiners, at a meeting held in Madison on May 22, licensed the following physicians in the practice of medicine after they had successfully passed an examination.

Name	School of Graduation	Year	Address
Anderson, Donald T.	Wisconsin	1945	Miller Hospital, St. Paul, Minnesota
Bennett, John C.	Northwestern	1945	461 Edward Street, Burlington
Brusky, Eugene S.	Marquette	1945	101 Washington Street, Green Bay
Cohen, David A.	Wisconsin	1945	2632 North Forty-ninth Street, Milwaukee
DeBoer, Arthur	Northwestern	1945	59 East Division Street, Chicago
Dick, Leo A.	Wisconsin	1945	139 Summit Avenue, St. Paul, Minnesota
Fetherston, William C.	Marquette	1945	1972 North Oakland Avenue, Milwaukee
Frank, Ralph C.	Harvard	1943	2103 North Thirty-sixth Street, Milwaukee
Green, Ray E.	Wisconsin	1945	415 St. Joseph's Street, Marshfield
Gallimore, Robert G.	Creighton	1943	340 Linden Street, Fond du Lac
Hunsader, Hugo N.	Wisconsin	1945	Box 31, Darien
Irvin, John M.	Wisconsin	1945	2614 North Eighty-first Street, Wauwatosa
Jacobson, Foster J.	Marquette	1945	2649 North Forty-fifth Street, Milwaukee
Malloy, Thomas Gregory	Marquette	1945	2025 North Fifty-first Street, Milwaukee
McGahey, William B.	Northwestern	1945	222 East Delaware Place, Chicago
McLaughlin, Brian C.	St. Louis	1945	2427 East Stratford Street, Milwaukee
Miller, Albert J.	Wisconsin	1945	108 North Randall Avenue, Madison
Misuraca, LeRoy	Wisconsin	1945	4529 North Twenty-fourth Place, Milwaukee
Quandt, Valerius V.	Wisconsin	1945	306 Dewey Avenue, Watertown
Roisum, Bryant H.	Wisconsin	1945	525 East Mifflin Street, Madison
Ruppa, Rex	Marquette	1945	1555 East Olive Street, Milwaukee
Sievers, David J.	Wisconsin	1945	906 East Third Street, Merrill
Smith, Robin	Wisconsin	1945	Neenah
Stack, Edward G. J., Jr.	Marquette	1945	1822 Missouri Avenue, Superior
Szujewski, Henry A.	Wisconsin	1944	1300 University Avenue, Madison
Werner, Walter A.	Wisconsin	1945	109 North Spooner Street, Madison
Wolfe, William A.	Northwestern	1945	414 North Union Street, Appleton

DOCTOR TENNEY REPORTS

The physicians' questionnaires for the Wisconsin Child Health Study are now in the hands of the Milwaukee physicians.

It has been very gratifying to the staff conducting the survey to have 75 per cent of the questionnaires returned from the physicians. This figure is exclusive of Milwaukee and it is felt that when the report is completed from Milwaukee there will be a 75 per cent coverage of the entire state.

If any physician hasn't had an opportunity to get at his mail, the staff would appreciate receiving a delayed answer to the questionnaire.

Physicians in Service

For many months material in this section was carried under the title of "The Nation at War." With physicians still entering service, with many returning to reestablish themselves in civilian practice, and with many planning to continue in service for an indefinite time, it is the decision of the *Journal* to continue the section under a more timely title.

Returning Veterans

J. T. F. GALLAGHER

Dr. John T. F. Gallagher, Madison, was recently discharged from the Army Medical Corps and returned July 1 to the staff of the Jackson Clinic and Methodist Hospital, Madison, as head of the department of orthopedics, the position he held for five years before enlisting in September, 1943.

Doctor Gallagher was stationed at Thayer General Hospital, Nashville, Tennessee, before going overseas in 1944. At Finchaven, New Guinea, he was chief of orthopedics at the 120th General Hospital 2d Field, and then at the 364th Station Hospital. Later he served at the 107th Station Hospital, Lingayen Gulf,; the 120th General Hospital, Manila; and the 4th General Hospital, Fort McHenry, Luzon.

Lieutenant Norman Clausen of Madison, who was called to active duty in the Naval Reserve September 6, 1944 at completion of his internship, received his release from military service June 17. His terminal leave expired August 9.

Lieutenant Clausen first reported for duty at the Naval Dispensary, PSNY Navy Yard, Bremerton, Washington. After two months as ward medical officer there, he served as industrial medical officer at the Naval Torpedo Station, Keyport, Washington, for three months. The doctor was then transferred to Chemical Warfare Research, Naval Research Laboratory, Washington, D. C., where he served six months.

The doctor spent the past year in the department of pharmacology, Naval Medical Research Institute at Bethesda, Maryland, and became head of the department a short time before his discharge. He is a wearer of the American Theater ribbon.

On July 1, Lieutenant Clausen became head of the New Drug Section, Medical Division, Food and Drug Administration, in Washington, D. C.

Lieutenant Commander James G. Garland of Milwaukee received his discharge from the Navy May 7. He entered the service November 30, 1944, and was assigned to the U. S. Naval Hospital at Mare Island, California. From March, 1945, to March, 1946, the doctor served aboard the USS Gasconade (APA 85) as senior medical officer and ship's surgeon for 50,000 miles on the Pacific. He was in Tokyo Bay during the signing of the peace treaty there.

Commander Garland's last duty was at the U. S. Naval Hospital (Surgery) at Aiea Heights, Hawaii. He wears the American Theater, Asiatic–Pacific Theater, and Philippine Liberation ribbons, and the Selective Service Medal.

The doctor has reopened his office in Milwaukee and is attending surgeon at the Milwaukee County and St. Luke's Hospitals. He is also assistant professor of surgery at Marquette University School of Medicine.

Colonel E. Frank Castaldo of Laona, who entered the Army Medical Corps in May, 1941, received a discharge March 2. Beginning active duty, Colonel Castaldo was sent to Carlisle Barracks, Pennsylvania, for a month and then was assigned duty at Fort Custer, Michigan, for a year. In August, 1942, the doctor became executive officer of the 12th General Hospital and served in that capacity in Indianapolis; Oran, Algeria; and Naples, Rome and Leghorn, Italy, until October, 1945. Colonel Castaldo wears the American Defense, American Theater, and European Theater of Operations ribbons with three battle stars. He was awarded the Bronze Star Medal.

Eau Claire physician, Captain Simon Cherkasky, received a discharge from the Army July 22, and has resumed his practice. Entering military service in October, 1943, the doctor was assigned duty with the 3d AAFBU (Aviation Engineers) at MacDill Field, Tampa, Florida, until November, 1945. From February 1, 1946 to June 30, 1946, Captain Cherkasky served on Okinawa with Headquarters, 4th Air Service Area Command. He wears the Ryukyu Occupation, Asiastic–Pacific Theater, and American Theater ribbons.

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SEARLE RESEARCH IN THE SERVICE OF MEDICINE

Former Prairie du Sac practitioner, **Lieutenant Emery M. Randall**, was discharged recently after two and one half years in the Navy, and has joined his father, **Dr. M. W. Randall** and **Dr. E. F. Freymiller** in forming the new Brookside–Parker Clinic in Boscobel. During the war, Lieutenant Randall was stationed on a destroyer with the 5th and 7th task forces in the Pacific, and saw action at Saipan, Tinian, Borneo, and the Philippines. He spent two months at the Farragut Naval Hospital, Idaho, and eight months at the hospital at Great Lakes, Illinois. Following his discharge, the doctor took a postgraduate course in general surgery at the Cook County Hospital in Chicago.

Colonel Walter T. Becker, former Milwaukee practitioner, after completing over five years of military service with the Army, received a discharge March 4, and has located at Wausau. The doctor was on active duty with the 135th Medical Regiment and the 135th Medical Group within the country and in the Southwest Pacific from January 31, 1941, to February 16, 1945.

Colonel Becker wears the American and Asiatic–Pacific Theater, American Defense, and Philippine Liberation (with bronze star) ribbons, with star awards for the East Indies, Papua, Bismark Archipelago, New Guinea, South Philippines, and Luzon. He also holds the Legion of Merit Award.

Major Paul C. Dietz, formerly of Milwaukee, has returned to civilian life after over two and one half years in military service, and is working at Evanston Hospital, Evanston, Illinois. Major Dietz entered the Army Medical Corps in December, 1943, and was discharged August 6, 1946.

Stationed first at Carlisle Barracks, Pennsylvania, and Warner Robins Army Air Base, Robins, Virginia, the doctor was assigned duty with the 329th Station Hospital in Alaska from May 6, 1944, to October 26, 1945. He then transferred to the 183d Regional Hospital at Anchorage, Alaska, serving there until May of 1946. Major Dietz wears the Asiatic–Pacific Theater and Army Commendation ribbons.

Milwaukee physician, **Lieutenant Commander Gervase S. Flaherty**, was discharged from the Navy recently after two years of active duty, and has reopened his office. He entered the service May 23, 1944. While in service, the doctor attended the School of Aviation Medicine at Pensacola, Florida, and became a flight surgeon. Later he was ordered to Alameda, California, where he was appointed chief of surgical service.

Major Rogers E. Garrison of Wisconsin Rapids, who served as a physician in the Army Air Forces for almost four years, received his discharge June 1. Upon entering military service on August, 1942, Major Garrison was assigned duty at the Station Hospital, Santa Ana, California. Later he served at these stations: Base Hospital, Eglin Field, Florida; the Arctic–Desert–Tropic Information Center, AAF Headquarters A 2, New York City; and Station Hospital, Drew Field, Florida.

Overseas he was assigned duty with the 55th Field Hospital 192 MDA, 184 and 187 MDA BADA at Burtonwood, England, and with USAFE at Wiesbaden, Germany. Returning to this country in February, 1946, the doctor was released from active duty. Major Garrison wears the American Defense and European Theater of Operations ribbons.

Former De Soto practitioner, **Captain Lester M. Gorenstein**, has received his release from active duty with the Army, and has started a practice in La Crosse. Captain Gorenstein's terminal leave will expire August 25. The doctor joined the 12th Armored Division in July, 1944, and served with it in the European Theater—England, France, and Germany—until his release. He is entitled to wear the American Defense and European Theater of Operations ribbons with two combat participation stars.

Major Thorolf E. Gundersen of La Crosse, has returned to civilian life and practice after receiving a discharge from the Army December 27, 1945. Major Gundersen began military duty in December, 1942, at Camp Hale, Colorado, with the 10th Medical Battalion. A month later he transferred to the 99th Infantry Battalion, serving with that battalion at Camp Hale and in Europe. From September, 1944, to May, 1945, he was on duty with the 4th Convalescent Hospital, also in the European Theater. Major Gundersen wears the European Theater of Operations ribbon with five combat stars, and was awarded the Bronze Star.

Captain Milton L. Kuhs, a native of Ripon, recently discharged after serving three years as surgeon with the Army Air Forces, has taken over the practice of **Dr. Herman Hendrickson** in Green Bay. Doctor Hendrickson, practicing physician for the last thirty-six years, retired July 1.

While in military service, Captain Kuhs served at air base hospitals in New Orleans, Louisiana, and Mobile, Alabama. He spent two years overseas in the European Theater, and received his discharge in January.

Captain Franklin J. Mellencamp has resumed his practice in Milwaukee after serving from March, 1943, to July 9, 1946 in the Army Medical Corps. Following induction, Captain Mellencamp was stationed at Billings General Hospital, Fort Benjamin Harrison; Fletcher General Hospital, Cambridge, Ohio; and Regional Hospital, Fort Knox, Kentucky. He wears the American Theater ribbon.

Lieutenant David C. Boyce of Wauwatosa, received a discharge July 3, after serving for over four years with the Navy and the Marine Corps. Lieutenant

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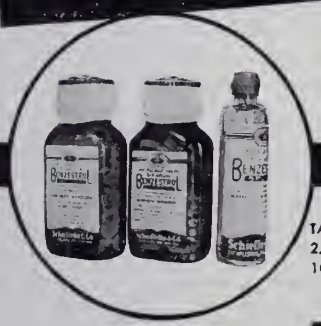

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Literature and Sample on Request

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Boyce was commissioned March 3, 1942 and served at the following posts: Naval Hospital, Great Lakes, Illinois; Lido Beach, Long Island, New York; USS LST 534, Fowey, Cornwall, England; USS LST 347; Vicerage Barracks, Plymouth, England; Base Two, Roseneath, Scotland; USS Albemarle; 1st N. D., Boston; School of Aviation Medicine, Pensacola, Florida; Naval Air Station, Key West; Marine Corps Air Station, Cherry Point, and Auxiliary Air Station, Oak Grove, New Bern, North Carolina; and the Seperation Center, Great Lakes.

J. T. MORRISON

Lieutenant Colonel John T. Morrison has resumed his position as associate director of the rural hospital division of The Commonwealth Fund, New York City, following three and one half years of military service. Colonel Morrison went on active duty with the Army in November, 1942 and was discharged March 17, 1946. The doctor's record shows he served at the following stations: Walter Reed Hospital, Washington, D. C.; Camp Patrick Henry staging area of Hampton Roads, Virginia, port of embarkation; Camp Custer, Michigan; and the Yale School for Military Government, New Haven, Connecticut.

Sent overseas in March, 1944, Colonel Morrison served with the European Civil Affairs Division in England, France, Belgium, Holland, and Luxemburg, and with the European Military Government Division in Marburg and Wiesbaden, Germany. He returned to this country in December, 1945.

Colonel Morrison is a wearer of the Victory ribbon of World War I, and the American Theater, European Theater of Operations (with five campaign stars), and Occupation ribbons. He also has the Legion of Merit award.

Lieutenant C. P. Reslock has reopened his office in Waupun recently after securing a release from active duty with the Navy. Lieutenant Reslock reported for military duty December 3, 1943 and served at Farragut, Idaho; with the Troop Training Unit, Amphibian Training Force in the Pacific; at San Luis Obispo, California; aboard the USS Livingston and the USS Coghlan; and at La Canada, California.

Milwaukee physician, **Major Sidney E. Wasserman**, who entered the Army Medical Corps in March, 1942, was discharged June 14. He was on duty first at station hospitals in the Alaskan Theater. From December, 1943 until his discharge, he served within the country at portable surgical hospitals and general hospitals. Major Wasserman wears the Asiatic–Pacific and American Theater ribbons.

Lieutenant Commander Maurice E. Monroe has returned to his practice in Hartford after an absence of three years. The doctor entered the Navy February 22, 1943 and was discharged March 4, 1946. He rendered service at the following stations: Medical Dispensary, Washington Navy Yard; Anacostia Receiving Station, Washington, D. C.; aboard the USS Hannibal as medical officer; and as assistant medical officer at the main dispensary, Great Lakes, Illinois. Commander Monroe wears the American Defense ribbon.

Captain Marcus K. Mookerjee has returned to Milwaukee to resume his practice that was interrupted four years ago, August, 1942, when he joined the Army Medical Corps. Captain Mookerjee received his discharge August 4, after serving with the 2d Battalion, 64th Medical Regiment at Camp Young, Indio, California; the 1st Battalion, 64th Medical Regiment at Camp Bowie, Texas; and in the Station Hospital, Fort Sill, Oklahoma. Captain Mookerjee is a wearer of the American Defense ribbon.

Following his discharge from the Army May 24, **Captain Benjamin A. Ruskin** returned to Milwaukee and is working at the Milwaukee Sanitarium. Upon entering the Army in July of 1942, Captain Ruskin reported for duty at Billings General Hospital, Fort Benjamin Harrison. In December, 1942, he was transferred to the 17th Field Hospital, serving in Texas, and in the central and northern Solomon Islands. Returning from overseas in June, 1944, the doctor rendered service at O'Reilly General Hospital, Springfield, Missouri, and the Convalescent Hospital, Fort Story, Virginia, until his release from active duty. Captain Ruskin wears the American Defense ribbon and the Asiatic–Pacific Theater ribbon with stars for Guadalcanal and New Georgia.

Major Anthony J. Sanfelippo of Milwaukee received a discharge from the Army May 16 after two years of service. He began active duty in March, 1944, and served with the Veterans Administration at Wood, Wisconsin.

Former Madison physician, **Lieutenant Roland R. Benson**, received a discharge from the Navy June 9, and became the radiologist at St. Mary's Hospital in Grand Rapids, Michigan. Lieutenant Benson began active duty with the Navy in July, 1944, and served at the following posts: Naval Hospital, Farragut, Idaho; Naval Base Hospital #6, Espiritu Santa, New Hebrides; Base Hospital #10, Sydney, Australia; Base Hospital #14, Cavite, Philippine Islands; and Naval Receiving Station #926, Guam, Marianna Islands. He is entitled to wear the Asiatic–Pacific Theater and the Philippine Campaign ribbons.

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DOSAGE: For average menopausal symptoms 0.33 mg. (2000 R.U.) once or twice weekly. Severe symptoms, as after surgical or x-ray castration, may require 1.0 mg. to 1.66 mg. (6000 to 10,000 R.U.) per injection.

PROGYNON-B available in ampules of 1 cc. containing 0.08 mg. (500 R.U.), 0.16 mg. (1000 R.U.), 0.33 mg. (2000 R.U.), 1.0 mg. (6000 R.U.) and 1.66 mg. (10,000 R.U.).

Trade-Mark PROGYNON-B—Reg. U.S. Pat. Off.

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Commander Leonard J. Schneeberger returned to his civilian medical practice in Milwaukee after receiving a discharge from the Navy, February 13. He entered the service October 12, 1942, and spent eighteen months overseas. Commander Schneeberger's first post was the Puget Sound Navy Yards at Bremerton, Washington. In March, 1943, he was sent to the U. S. Naval Barracks at Portland, Oregon. The doctor was then stationed at Mare Island, California, until June 1, 1944, when he reported overseas for service in the Pacific, on Tinian and Saipan, and later on the hospital ship, USS Solace. He wears the Pacific Theater ribbon with two stars and the American Theater ribbon.

Lieutenant (j.g.) James W. Christofferson of Waupaca was discharged from the Navy June 15, and has started a year's residency at St. Joseph's Hospital in Marshfield. He entered the Navy July 7, 1945 from internship and served as senior medical officer aboard the USS Menard APA 201, in the Pacific.

Former Adams practitioner, Major Harry Shapiro, received a discharge from the Army May 29, and has started his practice in Santa Barbara, California. The doctor began his Army duty July 20, 1942 and served in the War Department Personnel Center at Fort Snelling, Minnesota. He is entitled to wear the American Theater ribbon.

Commander Wilson James Troup has returned to Green Bay to resume his practice that was interrupted in March of 1943 by his entrance into the Navy. Commander Troup received his discharge from the Navy April 15, after serving at the following stations: U. S. Naval Hospital, Bethesda, Maryland; Base Hospital #12, Netley, England; U. S. Naval Hospital, Portsmouth, Virginia; and the U. S. Naval Hospital at New Orleans. Commander Troup wears the American and European–African Theater ribbons.

VETERAN PHYSICIANS' EXCHANGE

This page will be devoted to a classified section, open without charge to: (a) veteran members desiring location and (b) other members having professional openings suitable for men returning from military service.

LOCATIONS WANTED

LOCATION WANTED: General surgeon, 36, who has completed first part of American Board examinations, served in charge of general surgery section in general hospital while in the Army, and is licensed in Wisconsin and Minnesota, desires clinic connection in this region. Wiil also consider associatlon with internist or small group on a share office basis. Available about August 1. Address No. 129 in care of the Journal.

LOCATION WANTED by young, married, Protestant doctor of Norwegian descent. Has done general practice in small country town for past 8 years. Two years Army service with honorable discharge. Graduate of a class A medical school and at present practicing at location occupied prior to Army service. Desires association with busy doctor doing own surgery in small city with hospital facilities. References gladly exchanged. Personal interview can be arranged. Address No. 130 in care of the Journal.

ASSOCIATION WANTED: Army veteran, age 34, with 5½ years of surgical training, desires association with a surgeon, or a position as surgeon for a group, clinic, or community. Excellent references. Address No. 131 in care of the Journal.

WANTED: Location or association, by veteran physician with 2 years general practice and over 2 years experience in general and orthopedic surgery in overseas general hospital. Prefer town with population over 2,500. Housing needed for family. Address No. 132 in care of the Journal.

LOCATION WANTED as business manager of hospital, clinic, or sanitarium. Please note Physicians' Exchange item No. 51 on page 730 of this issue.

ASSISTANCE WANTED

WANTED: Good opportunity for permanent position in general practice open now in a Southern Wisconsin Clinic. The work involves some surgery, obstetrics, general and industrial medicine. Percentage basis considered. Address No. 105 in care of the Journal.

ASSISTANT WANTED: Young man well trained in obstetrics and surgery for assistantship with busy general practitioner located in the heart of Milwaukee. Office well equipped and staffed. Association on increasing percentage, leading to partnership. Address No. 127 in care of the Journal.

VETERAN PHYSICIANS: This is a strategic time to enter public health. State Board of Health has 2 openings for physicians with executive ability as directors of the tuberculosis and venereal disease divisions. Salary $4,800 to $5,400 plus necessary traveling expenses, Madison headquarters. 5 district health officers also needed. If you were under 40 when entering the armed services and can otherwise qualify, write Dr. Carl N. Neupert, State Health Officer, Madison 2, Wisconsin.

WANTED: Staff physician at sanatorium approved for tuberculosis residency. Beginning salary $250–$300, less modest maintenance deduction. One position open after July 1. Wisconsin licensure required. Person must have good professional and personal qualities. Write Superintendent, Wisconsin State Sanatorium, Statesan, Wisconsin.

For additional classified advertisements, see the Physicians' Exchange, page 814

Star of hope in petit mal . . . .

For thousands of children laboring under the social and educational handicaps imposed by petit mal, Tridione, a product of Abbott research, offers new hope. In one series of cases, for example, Tridione was administered to a group of 50 patients suffering from petit mal, myoclonic or akinetic seizures *which had not responded to other medication.* In a period of days to weeks, the seizures ceased in 28 percent of the cases, were reduced to less than one-fourth of the usual number in 52 percent, and were little affected in 20 percent. In several instances, the seizures once stopped *did not return* when medication was discontinued. Tridione has also been shown to have a beneficial effect in the control of a certain proportion of psychomotor cases. Tridione is supplied in 0.3-Gm. capsules, bottles of 100. Literature on request. ABBOTT LABORATORIES, North Chicago, Ill.

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Richards, R. K., and Perlstein, M. A. (1945), Tridione, A New Experimental Drug for the Treatment of Convulsive and Related Disorders, Proc. Chicago Neurological Soc., Jan. 9; and (1946), Arch. Neurol. and Psychiatry, 55:164, February.

Lennox, W. G. (1945), Petit Mal Epilepsies: Their Treatment with Tridione, J. Amer. Med. Assn., 129:1069, December 15.

DeJong, R. N. (1946), Effect of Tridione in the Control of Psychomotor Attacks, J. Amer. Med. Assn., 130:565, March 2.

THE WOMAN'S AUXILIARY

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Eighteenth Annual Meeting of Auxiliary to Be Held in Milwaukee, October 6, 7, 8

Convention Chairman Issues Invitation

MRS. A. J. McCAREY
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President

MRS. W. C. LIEFERT
Milwaukee
Convention Chairman

Dear Auxiliary Member:

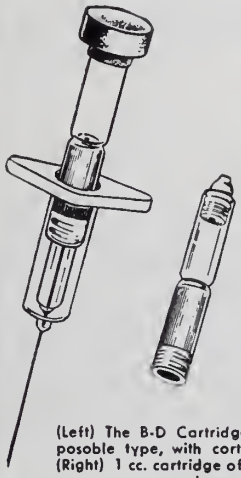
Draw a big red circle around the dates October 6, 7, 8 on your engagement calendar. Plan now to attend this year's Convention of the Woman's Auxiliary to the State Medical Society to be held at the Hotel Schroeder, Milwaukee.

Mrs. Arthur James McCarey, our state president, will preside at the preconvention dinner of the Board of Directors and at the business sessions on Monday and Tuesday. Exciting plans for social functions and meetings to interest and entertain you will be announced in detail in the September issue of *The Journal.*

Here we give you just a hint of what is in store for you . . . our first post-war style show! A group of talented Milwaukee amateur actresses presenting a reading of a current Broadway hit! Outstanding speakers! Good food! Everything to make your visit a memorable and enjoyable one! Hotels are still crowded, so make your reservations early!

Very sincerely yours,
HELEN C. LIEFERT
Convention Chairman

Announcing Easier Administration of Penicillin in Oil and Wax



(Left) The B-D Cartridge Syringe, disposable type, with cartridge inserted. (Right) 1 cc. cartridge of penicillin in oil and wax.

The B-D Metal Cartridge Syringe with cartridge inserted.

Bristol Laboratories now introduce two techniques which are designed to make the administration of penicillin easier and more practical. Both of them make use of a 1 cc. glass cartridge of Penicillin in Oil and Wax. A completely new feature of the Bristol Cartridge is a specially designed rubber stopper which permits an aspirating test to prevent venoclysis.

Bristol Cartridges may be used anywhere, any time with the B-D Cartridge Syringe, Disposable Type. (Above) For office or hospital, many physicians will prefer the B-D Metal Cartridge Syringe. (Left)

In addition to the 1 cc. cartridges, Bristol Penicillin in Oil and Wax is still available in 10 cc. rubber-stoppered vials, for those who prefer to employ a Luer-lock syringe. All forms are available through your regular source of supply.

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SYRACUSE 1, NEW YORK

News Items and Personals

The role of the Medical Corps during World War II was described by *Dr. Rogers E. Garrison* of Wisconsin Rapids when he appeared as guest speaker at the weekly luncheon of the Wisconsin Rapids Rotary Club at the Hotel Witter, July 3. The doctor, recently released from military service, mentioned briefly the new set of problems confronting the medical corps which have developed in the air corps—problems caused by the rapid development of planes which fly too fast and too high for human beings to stand. He said that battle surgery went through its first rehearsal in the Spanish War and emerged from that conflict with well established principles. World War II witnessed the carrying out of those principles.

—△—

After practicing medicine in Milwaukee for thirty-five years, *Dr. Daniel M. Loughlin*, 68, retired recently. The doctor, who is making his home now at Okauchee Lake, has been professor of anatomy at Marquette University Dental School for the last thirty years.

—△—

Dr. Tryggve A. Hagerup, Dodgeville physician and surgeon, left June 30 for a two month trip to Norway, his old home. He sailed from New York on the SS Marine Perch, planning to visit first at Aalesund, Norway, with his mother, and then see his brother in Oslo. Doctor Hagerup last visited his native land six years ago.

—△—

At a staff meeting of Theda Clark Memorial Hospital in Neenah, June 28, *Dr. Thaddeus D. Smith* of that city was re-elected president of the staff. *Dr. George N. Pratt, Jr.*, of Menasha, was chosen to succeed himself as vice-president, and *Dr. Roy C. Lowe*, Neenah, was re-elected secretary–treasurer.

—△—

Janesville physician and surgeon, *Dr. Joseph F. Kelley*, recently received an appointment from Washington as medical examiner for the civil aeronautical authority (C. A. A.) for the Janesville area. Serving as first president of Janesville chapter, N. C. A., Doctor Kelley was also the first department of commerce medical examiner for that area.

For more than three years during the war, the doctor, then Major Kelley, was a flight surgeon with the 75th tactical reconnaisance group, serving as squadron surgeon and then as base surgeon. He was discharged in February and resumed his practice in Janesville.

—△—

Physicians and surgeons from northern Wisconsin joined Michigan practitioners in attending the June 20 meeting of the Gogebic County Medical Society (Michigan) at the Grand View Hospital, Ironwood, Michigan. The speakers were Dr. R. R. Kaerland, who discussed "Penicillin in Treatment of Syphilis," and Dr. B. T. Horton of Mayo Clinic, who spoke on "Clinical Use of Histamine."

—△—

Dr. Chester M. Kurtz of Madison, who recently purchased a small airplane, made a trip to California in the plane the last week of June to attend the American Heart Association meetings, June 27 and 28, in San Francisco. The doctor plans to use his plane not only for his own enjoyment, but in connection with his practice—flying to visit out of town patients, and meeting his speaking commitments throughout this area.

—△—

Menomonie Rotary Club members gathered at the La Corte, July 10, to hear an informative talk on pencillin, its discovery and use, presented by *Dr. Arthur E. McMahon* of Menomonie. Discussing pencillin, Doctor McMahon pointed out that the credit for the perfection and development of mass production of the drug to the point where it is now readily available to hospitals and physicians, goes to the enterprise of the American pharmaceutical industries.

Society Proceedings

Fond du Lac

Dr. Arnold S. Jackson and *Dr. Arthur C. Stirling*, both of Madison, provided the program for the Fond du Lac County Medical Society meeting June 27, at the Hotel Retlaw, Green Bay. At this last meeting of the season, Doctor Jackson presented a lecture entitled, "The Acute Surgical Abdomen," and Doctor Stirling spoke on "Ruptured Intervertebral Discs."

Marathon

Meeting at the Hotel Wausau in Wausau, June 26, the Marathon County Medical Society members heard a report on the House of Delegates meeting held in Madison June 22, delivered by *Dr. H. H. Christiansen*. A discussion period followed the report.

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National Society for the Prevention of Blindness

A three day conference, November 25, 26, and 27, is being planned by the National Society for the Prevention of Blindness. The conference, designed to be of interest to persons directly or indirectly concerned with eye health and safety, will be held at the Hotel Pennsylvania in New York City.

Ninth Councilor District Medical Society

At a summer dinner meeting in Wausau, July 25, at the Hotel Wausau, the Ninth Councilor District Medical Society heard Dr. Edith Potter of the department of pathology, University of Chicago, speak on "The Causes of Fetal and Neonatal Mortality." *Dr. Orville R. Kelley,* pathologist at St. Mary's Hospital, Wausau, discussed the laboratory diagnosis of tropical diseases. The meeting was presided over by *Dr. Lyman A. Copps,* Marshfield, society president.

Tenth Councilor District Medical Society

Eau Claire will be the meeting place for the Tenth Councilor District Medical Society, September 26. The activities planned for the day are as follows:

Morning program—Luther Hospital

9:30 a. m.—A paper on "Amenorrhea," by *Dr. John McKelvey,* University of Minnesota.

10:00 a. m.—A symposium on "Gallbladder Diseases with Gallstones," by *Drs. H. C. Huston,* Eau Claire; *James F. Weir,* and *Howard Gray,* Mayo Clinic; *D. Murray Angevine,* University of Wisconsin; and *John McKelvey,* University of Minnesota.

Afternoon program—Elks Club

Dr. John McKelvey—"Placenta Previa."

Dr. James F. Weir—Undecided as yet.

Dr. Howard Gray—"Surgical Management of Lesions of the Pancreas."

Dr. D. Murray Angevine—"Pathology of Joints, Tendons, and Bursae."

Evening program

6:00 p. m.—Dinner and entertainment.

Winnebago

Members of the Winnebago County Medical Society held their annual picnic Saturday, August 3, at the Oshkosh Power Boat Club, Butte des Morts, with food and prizes for all present.

Eleventh Councilor District Medical Society

Members of the Eleventh Councilor District Medical Society gathered July 18 at the American Legion Home in Ashland for an afternoon and evening of talks. The program follows:

"Common Skin Diseases"—*Dr. Frederic T. Becker*

"Inguinal Hernia"—*Dr. J. H. Pratt,* Rochester, Minnesota

"Safety Factors in Obstetrics"—*Dr. T. A. Leonard,* Madison

"Case Report"—*Dr. James McGill,* Superior

Dinner—6:30 p. m.

Address by State Medical Society President, *Dr. P. R. Minahan,* Green Bay.

"Hepatic Disease" — *Dr. Frederick Pohle,* Madison.

In executive session, the members passed a resolution, that has been presented to the Council of the State Medical Society, condemning the present trend in nursing education in the state. The members recognized the value of advanced nursing education standards, but felt that when the advanced standards forced smaller hospital training schools to close and caused a shortage of nurses, the standards should be modified. The members suggested that if the State Board of Nursing does not voluntarily lower the standards, proper legislative action by the State Medical Society should be instituted.

Association of Military Surgeons of the United States

Lieutenant General Walton H. Walker, commanding officer of the 5th Army, will serve as honorary chairman at the convention of the Association of Military Surgeons of the United States, planned for October 9–11, in Detroit.

The convention will formally open Wednesday morning, October 9, at 10 a. m. in the Hotel Book–Cadillac. Highlighting the initial session will be the address delivered by Colonel Ervin Abel, president of the association, and the addresses by the Surgeons General, Major General Norman T. Kirk of the U. S. Army, Vice-Admiral Ross T. McIntire of the U. S. Navy, Dr. Thomas Parran of the United States Public Health Service, and Major General Paul R. Hawley of the Veterans Administration. Members of the association who plan to attend the convention should make their reservations early in order to secure accommodations.

SOCIETY RECORDS

New Members

Nathaniel C. Schlossman, 324 West Main Street, Waukesha.

Ray C. Johnston, 1545 South Layton, Milwaukee.

James S. Feurig, Brusky Clinic, Green Bay.

John W. Boren, Jr., 1510 Main Street, Marinette.

Herbert M. Snodgrass, Pember-Nuzum Clinic, Janesville.

Everett W. Reinardy, 19 South Main Street, Janesville.

John R. Schroder, 500 West Milwaukee Street, Janesville.

George H. Peterson, Fairbanks Morse and Company, Beloit.

Mark A. Foster, 515 East Gorham Street, Madison.

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Donald L. Dickerson, Jackson Clinic, Madison.
Richard L. Kennedy, 314 East Grand Avenue, Eau Claire.
Richard M. Rogers, Whitehall.
Milton L. Kuhs, 310 West Walnut Street, Green Bay.
Henry C. Rosenstiel, Sheboygan Clinic, Sheboygan.
William W. Moir, 1300 University Avenue, Madison.
Arvin B. Weinstein, 1300 University Avenue, Madison.
William I. Norton, 1300 University Avenue, Madison.
Karl H. Stahmer, 310½ First Avenue, South, Wausau.
John P. O'Brien, 104 South Main Street, Fond du Lac.
Richard Forreger, Veterans Administration, Wood.
James E. Conley, 425 East Wisconsin Avenue, Milwaukee.
Richard P. Cramer, 1700 South Sixtieth Street, Milwaukee.
Joseph E. Vaccaro, Milwaukee County Hospital, Milwaukee.
Joseph R. Stone, 536 West Wisconsin Avenue, Milwaukee.
Emanuel Horwitz, 3533 North Frederick Avenue, Milwaukee.
Carl R. Newman, Milwaukee County Hospital, Milwaukee.
Roy C. Richardson, 161 West Wisconsin Avenue, Milwaukee.
Edward I. Feldman, 208 East Wisconsin Avenue, Milwaukee.
Warren R. Tuft, 3520 West National Avenue, Milwaukee.
Owen Royce, Jr., 2214 North Terrace, Milwaukee.
John T. Murphy, 1022 North Tenth Street, Milwaukee.
Irwin E. Gaynon, 231 West Wisconsin Avenue, Milwaukee.
Clement F. Neacy, 2647 South Kinnickinnic Avenue, Milwaukee.
Sidney G. Babbitz, 231 West Wisconsin Avenue, Milwaukee.
Douglas A. Gutheil, Muirdale Sanitarium, Wauwatosa.
John G. Slaney, Veterans Administration, Wood.
Lester V. Salinsky, 208 East Wisconsin Avenue, Milwaukee.
Paul E. Millington, 2137 North Forty-seventh Street, Milwaukee.
Robert M. Moore, Frederic Clinic, Frederic.
Richard C. Shannon, 605½ Third Street, Wausau.
Francis C. Johnson, 506½ Third Street, Wausau.

Changes in Address

R. C. Deming, Madison, to 764 Union Street, Jackson, Michigan.
W. T. Becker, Milwaukee, to 210 Washington Street, Wausau.

THIRD DISTRICT PHARMACISTS

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B. J. Peters, West Allis, to 161 West Wisconsin Avenue, Milwaukee.

M. W. Randall, Blue River, to Boscobel.

R. R. Rivard, Manhattan, Kansas, to Shawano.

J. J. Boersma, Madison, to 306 Cherry Street, Green Bay.

D. W. Ovitt, Madison, to St. Thomas Hospital, Nashville, Tennessee.

K. F. Manz, Black River Falls, to Neillsville Clinic, Neillsville.

H. P. Dohn, Oklahoma City, Oklahoma, to 161 West Wisconsin Avenue, Milwaukee.

J. W. Guepe, Milwaukee, to 816 Wisconsin Street, Lake Geneva.

MARRIAGE

Dr. Francis M. Hauch, Appleton, and Miss Lorraine Calhoun, Waukegan, Illinois, on July 31.

DEATHS

Prominent Stevens Point physician and surgeon, Dr. **Rhody William** Rice, 45, died suddenly in a Madison hospital, Wednesday, June 26.

The doctor came to Madison for the meeting of the State Medical Society's House of Delegates over the weekend and on Tuesday, June 25, entered a hospital for a checkup.

Doctor Rice received his degree from the Marquette University School of Medicine in 1926, and after serving his internship at St. Mary's Hospital, Milwaukee, practiced in Milwaukee for a year. In 1928, he began practice in Stevens Point, associated with his late father, Dr. Daniel S. Rice, and later with his brother, Dr. Maurice Rice.

A member of the Portage County Medical Society and the State Medical Society, Doctor Rice held Fellowships in the American Medical Association and the American College of Surgeons. He was also a member of the staff of St. Michael's Hospital, Stevens Point.

The doctor is survived by his wife, two sons, and a daughter.

Dr. Wallace H. Vosburgh, 75, veteran Denmark and Cooperstown physician who was honored for fifty years of medical service June 4, with a public testimonial celebration, died Monday, July 8, in a Green Bay hospital following an illness of two weeks.

A native of Black Earth, and a graduate of the University of Illinois College of Medicine, Chicago, with the class of 1896, Doctor Vosburgh began practice in Cooperstown following internship at Cook County Hospital in Chicago. Later he opened another office in Denmark and maintained both offices until his death.

The doctor held memberships in the Brown–Kewaunee–Door County Medical Society the State Medical Society, and the American Medical Association.

Shortly before he died Doctor Vosburgh estimated that he had been present at the birth of 5,000 babies.

The doctor is survived by his wife.

Dr. John B. Ludden, 34, staff member at the Milwaukee Hospital, member of the adjunct staff of the Milwaukee Children's Hospital, and from 1942 to 1945 medical director of the Milwaukee plant of the International Harvester Company, died Wednesday, July 24, in a local hospital, following a long illness.

A native of Bloomington, Doctor Ludden graduated from the University of Wisconsin with the class of 1935, and received his M. D. degree from the Northwestern University Medical School, Chicago, in 1938. The doctor received a fellowship in medicine at the New York Post-Graduate Medical School and was junior assistant physician to the hospital and junior assistant physician to the dispensary there from August, 1939, to April, 1941. As research assistant in medicine, he worked a year at Columbia University, New York.

Doctor Ludden returned to Milwaukee, specializing in internal medicine, and served as lecturer in nursing education until June, 1943. He joined the Milwaukee Hospital staff in 1945.

A member of the Medical Society of Milwaukee County and of the State Medical Society, the doctor held a Fellowship in the American Medical Association. He was also a member of the Milwaukee Academy of Medicine, and the Internists' Club, the Central Society for Clinical Research, and the American Federation for Clinical Research.

Doctor Ludden is survived by his wife, one son, and one daughter.

Memorial services for physicians of Milwaukee County who died in military service in connection with World War II will be held at Ward Memorial Hospital, September 4, 1946, at 8:00 p. m. The services will be conducted by the Medical Veteran Organization (returning medical officers) of Milwaukee County.

Physicians whose service will be memorialized are:

George W. Fox, M. D., Milwaukee
Anthony J. Gramling, M. D., Milwaukee
William H. Millmann, M. D., Milwaukee
Jacob J. Horwitz, M. D., Milwaukee
Charles J. Allen, M. D., Milwaukee
John R. Pepin, M. D., Milwaukee

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Trade News

Individual Initiative Beat Regimentation in Development of New Antimalarial

While the same chemical formula lay dormant in Nazi laboratories, stifled by German regimentation, individual initiative, judgment and the production power of free enterprise in the United States has produced what is known as Aralen, a new potent drug for the war against malaria which afflicts 800,000,000 annually throughout the world, according to Dr. Justus B. Rice, vice-president in charge of medical research of the Winthrop Chemical Company, Inc.

Dr. Rice revealed July 13, for the first time, the complete inside story of how Aralen was first synthesized in Winthrop laboratories, where production problems have now been overcome. The tablets cure falciparum malaria, and relieve other acute forms of the disease three times faster than either Atabrine or quinine. The story was broadcast direct from the laboratories as one of a series sponsored by the National Association of Manufacturers over the Columbia Broadcasting System's network (3:45 to 4:00 P. M.).

"The keynote of the story, the fact that is putting the United States ahead of the rest of the world in the development of medicines and pharmaceutical preparations, is individual initiative and judgment," Dr. Rice declared.

"Unrestricted by government control, Dr. Alexander B. Surrey, young chemist on the Winthrop staff, began his own individual experiments on the particular chemical chain that eventuated in the synthesis of Aralen, known chemically as 7-chloro-4 (4-diethlyamino-1-methylbutylamino) quinoline diphosphate. The same drug was in Nazi hands but its importance was overlooked.

"Here in the United States as soon as possible after it was synthesized on March 1, 1944, experimental quantities were turned over to the National Research Council for screening and clinical testing. It was one of many different possible antimalarials submitted to NRC.

"This was a war measure. In the hands of the NRC Aralen became one of the 14,000 chemicals being tested as antimalarials. Given the laboratory number SN7618, it was eventually announced, after the most thorough possible experimentation for toxicity and potency with animals and human beings, as an important medical discovery. The NRC described it as a drug that accomplished cures usually in one day as compared to four or more days by the older drugs, and one that would suppress the more common type of malaria, called vivax, which, while usually non-fatal to adults, often is characterized by as many as 20 relapses within three years," Dr. Rice said.

The NRC is well satisfied with Aralen after having tested it on 5,000 subjects in the Army and Navy, according to Dr. Rice, and believes it will replace Atabrine and quinine. The drug promises to be a boon both to the military and to public health officials in areas where malaria is a constant problem because only two tablets a week are necessary to suppress the disease as compared with one tablet of Atabrine per day. Aralen possesses the additional benefit of not discoloring the skin.

Medical Literature For the Veteran Physician

A special compilation of informative literature on recent developments in endocrinology is being presented to each physician returning from service in the armed forces during the war. Publisher of this literature is the Schering Corporation, of Bloomfield and Union, New Jersey, manufacturers of endocrine, diagnostic and other pharmaceutical preparations.

The "Welcome Home" collection supplies information designed to help the military doctor bring himself up-to-date in civilian practice. It contains a copy of "Sex Endocrinology", the illustrated 96-page volume covering the physiology, chemistry and rationale of hormones in modern therapeutics. A "Handy Index" provides in brief outline form for the physician readily accessible and concise summaries on treatment and dosage of endocrine products. The accompanying copy of the Schering "Handbook" supplies to the physician technical information and product data on Schering pharmaceuticals.

Squibb Makes Thiouracil Available

Thiouracil, a new compound derived from thiourea, which has been found useful in controlling the major manifestations of hyperthyroidism, has recently been made available for prescription use by Squibb. Thiouracil is indicated in the treatment of hyperthyroid patients having either a diffuse toxic goiter or a single or multiple nodular goiter. It is recommended both for preoperative use and for the treatment of patients in whom surgery is contraindicated. It is also possible Thiouracil will be found of value in acute thyroiditis.

For patients in whom surgical treatment is contraindicated, the initial dose of Thiouracil is 0.4 Gm. daily by mouth taken as four divided doses to be administered every four hours during the waking hours. While some patients may require higher dosage, the maximum initial dose should be 0.8 Gm. daily. Maintenance dose is between 0.1 and 0.2 Gm. daily in divided doses. As preoperative treatment, 0.4 Gm. should be given daily in four divided doses during the waking hours and this dosage should be continued until hyperthyroid manifestations have subsided and the basal metabolic rate is normal.

PENICILLIN *by mouth*

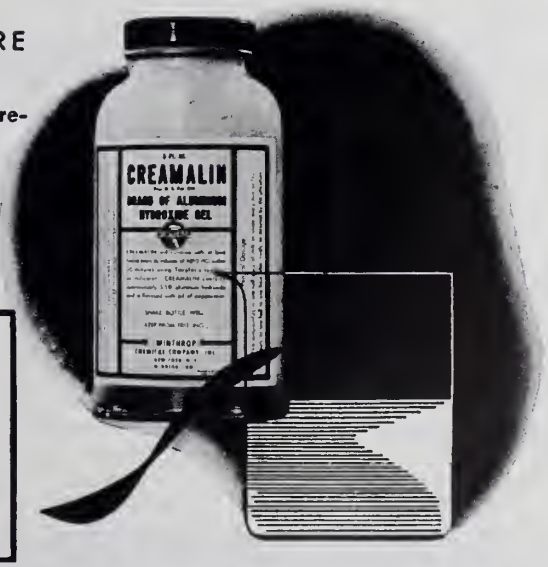
An effective way of administering Penicillin by mouth is in combination with the antacid Creamalin.

Each 100,000 units of Penicillin are dissolved in 20 cc. of water and mixed with 30 cc. of Creamalin gel. The mixture, which is stable for at least 24 hours without and for 30 days with refrigeration, is administered on an empty stomach (not less than 30 minutes before and not less than 1½ to 2 hours after eating a light meal) in doses of 25 cc. (50,000 units of Penicillin) every 2 or 3 hours.

Therapeutically effective blood levels of Penicillin are rapidly obtained and readily maintained in this manner.

WRITE FOR DETAILED LITERATURE

discussing indications, contraindications and precautions for oral Penicillin therapy.



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During the second and third weeks preceding operation, iodine is administered simultaneously with Thiouracil; then Thiouracil is discontinued and for the week preceding surgery, iodine alone is given.

Since granulocytopenia is a reaction with an estimated incidence of 2.5 per cent among patients taking Thiouracil, the patient should be warned to discontinue the drug and see his physician immediately if sore throat, fever, coryza or malaise are noted.

Stearns Improves Product Used For Hay Fever

An improved formula for Neo-Synephrine Ophthalmic (⅛ per cent), used by physicians for the symptomatic relief of hay fever, is announced by the Frederick Stearns & Co. Division, Sterling Drug Inc.

What has been changed, according to Dr. Melville Sahyun, vice-president in charge of research, is the base vehicle, which has been newly buffered to retain all the preparation's original qualities and remain stingless when placed in the eye.

Long years of clinical study have demonstrated that Neo-Synephrine Ophthalmic (⅛ per cent) is especially useful for relief of the eye symptoms of hay fever by virtue of its decongestant action on the capillary bed of the conjunctiva and on edematous puncta lacrimalia (outlets of nasolacrimal canals) which may be blocking the nasolacrimal ducts. Its decongestant action contributes to relief from itching and excessive watering of the eyes.

Technical explanations of the improved base of the formula involve the maintenance of the desired pH., or the hydrogen ion concentration in an isotonic solution. Stearns had determined the optimum pH for this product by consultation with leading opthalmologists and well controlled clinical application. The problem with Neo-Synephrine Ophthalmic (⅛ per cent), a problem common to many solutions of sympathomimetic drugs, is to protect the Neo-Synephrine Hydrochloride from oxidation by an antioxidant, without changing the pH or the isotonicity.

Under the new formula, the pH of the Ophthalmic Solution ⅛ is 6.0. According to Doctor Sahyun, stability tests have demonstrated that the new solution is not prone to alter its pH, nor is the Neo-Synephrine liable to oxidation. In addition, it has a uniform low surface tension which assures immediate uniform spread over the conjunctiva, the delicate membrane that lines the eyelids and covers the eyeball in front.

Parenamine Wins A. M. A. Acceptance

After ten years of clinical trial and five years of commercial distribution, Parenamine (Amino Acids) 15 per cent solution has been accepted by the Council on Pharmacy and Chemistry of the American Medical Association, it is announced here by Dr. Earl Burbidge, medical director of the Frederick Stearns & Co. Division, Sterling Drug Inc.

Original research on this Stearns product dates back to 1932, when Dr. Melville Sahyun, now vice-president in charge of research for the division, first started studies in the field of protein nutrition. Results of this research were published in 1936. Doctor Sahyun had become associated with Frederick Stearns & Co., in 1934, continuing his investigations in the acid hydrolysis of casein fortified with tryptophane as the method of choice for providing a safe and efficient product containing all the amino acids. Clinical trial of the material was instituted in 1936, and was made available to the medical profession in 1941.

During the entire period commencing in 1936, numerous clinical studies as well as laboratory tests have demonstrated the value of Parenamine in a wide variety of pathological conditions. Scientific papers published in medical journals have noted its marked efficacy in cases of protein deficiencies due to such causes as restricted intake, faulty absorption, increased need for and excessive loss of nitrogen.

Parenamine is proving particularly useful before and after operations, on patients with obstructions of the esophagus and stomach, for healing wounds and burns, and for providing required additional proteins in cases of pregnancy. Parenamine is used in many veterans hospitals for surgical cases, anemic patients, and as part of the regimen for tuberculosis.

Among recent publications reported on the results of the use of Parenamine, was one from the Hektoen Institute for Medical Research, Chicago. Parenamine was used in 11 out of 14 cases as the only source of protein during a study of obstructing lesions of the esophagus or stomach. The paper appeared in the *Archives of Surgery* (July–August, 1945, Vol. 51, pp. 59–68).

Other publications include A. R. Curreri and O. V. Hibma, Experiences with the Parenteral Use of Amino Acids, *Wisconsin Medical Journal* (June, 1944); W. E. Abbott and R. C. Mellers, Total Circulating Plasma Proteins in Surgical Patients with Dehydration and Malnutrition, *Archives of Surgery* (February, 1943); W. J. Messigner, Nitrogen Equilibrium and Regeneration of Serum Protein, *Archives of Internal Medicine* (January 16, 1943); J. H. Mulholland, Co Tui, A. M. Wright, V. Vinci and B. Shafiroff, Protein Metabolism and Bed Sores, *Annals of Surgery* (December, 1943); I. D. Fagin and F. T. Zinn, Cirrhosis of the Liver, *Journal of Laboratory and Clinical Medicine* (August, 1942); J. E. Corr, W. Wagner and M. Hetzer, Intravenous Amino Acids in Nephrotic Toxemia of Pregnancy, *American Journal of Obstetrics and Gynecology* (January, 1944); S. M. Levenson, C. S. Davidson, C. C. Lund, and F. H. L. Taylor, The Nutrition of Patients with Thermal Burns, *Surgery, Gynecology and Obstetrics* (May, 1945); and R. J. Block and D. Bolling, Essential Amino Acid Distribution in a Casein Hydolysate Suitable for Parenteral Injection, *The American Journal of Pharmacy* (October, 1944).

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THE JOURNAL BOOKSHELF

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, S. M. I. Building, Madison, Wis.

Manual of Diagnosis and Management of Peripheral Nerve Injuries. By Robert A. Groff, M. D., Lieutenant Colonel, M. C., A. U. S.; Formerly Assistant Professor of Surgery, Jefferson Medical College, and Assistant Professor of Neurosurgery, Graduate School of Medicine, University of Pennsylvania; and Sara Jane Houtz, B. S., First Lieutenant (P. T.) A. U. S. Pp. 188 with 111 illustrations. Philadelphia, London, and Montreal: J. B. Lippincott Company, 1945. Price $8.00.

This manual is unique for its illustrations. Especially commendable are the simple line drawings of part II illustrating muscle action and sensory deficit. This feature is particularly valuable to technicians and students of physical medicine. The neurologist will look in vain for neuroanatomic illustrations to augment the neurologic text. At the end of the book is a section containing six fine plates to show anatomic relationships of nerves and adjacent structures at shoulder (clavicular-brachial region), cubital fossa, wrist, ilio-inguinal thigh region, popliteal space and lateral view of knee. This section mistakenly carries the heading of cranial nerves and contains the only anatomic illustrations so necessary to the student of neurology. A section on cranial nerves is a valuable addition, but here, as elsewhere in the text, there is no discussion of the type or nature of the injury, nor localization of lesion, as is expected in a text on diagnosis of peripheral nerve injuries.

The authors and illustrators are to be congratulated upon an achievement conceived and executed in one of the most uncomfortable stations of war activity the Assam–Burma border during the monsoon season.

The publishers have clearly and neatly reproduced the work at a price that seems appalling. If the reviewer were acquainted with the problems of the printer of the type of illustration featured in this monograph, the price might prove to be justified. M. G. M.

Year Book of Industrial and Orthopedic Surgery. Edited by Charles F. Painter, M. D., Orthopedic Surgeon to the Massachusetts Women's Hospital and Beth Israel Hospital, Boston. Pp. 432 with 225 illustrations. Chicago: The Year Book Publishers, Inc., 1945. Price $3.00.

The value of any such book as this lies in the care exercised in choosing the articles. Secondly a Year Book's use and value are dependent upon the abstracting of these articles. This edition again shows a careful choice of industrial and orthopedic subjects as well as excellent abstracting of them. It should be of great use to those returning from service who have not been able to follow the literature carefully during the year.

Two most important sections are the review of the latest drugs and treatment in arthritis and the last section on industrial medicine including hazards arising during the war period. J. E. M.

Howell's Textbook of Physiology. Edited by John F. Fulton, M. D., Sterling Professor of Physiology, Yale University School of Medicine. Ed. 15. Pp. 1304 with 507 illustrations. Philadelphia and London: W. B. Saunders Company, 1946. Price $8.00.

The Fulton edition of *Howell's Textbook of Physiology* is essentially a new book and bears very little resemblance to the fourteenth edition of this distinguished text. The Fulton edition is an excellent reference source, particularly for the nervous system. The references to the literature are fairly complete and up-to-date. As a textbook it leaves a great deal to be desired. The style of the discussion is that characteristic of a monograph and not well suited for a medical student beginning his study of physiology. Thirty-eight per cent of the text is used for nerve and the nervous system. This, for the usual class in physiology, is an excessive expansion of this phase of the subject. Metabolism and nutrition seem to be somewhat curtailed in that only 8 per cent of the text is used for this subject. It seems undesirable that the physiology of the endocrines, other than that of the sex hormones, should be dispersed through the discussion of the other subjects rather than giving it a separate chapter. R. C. H.

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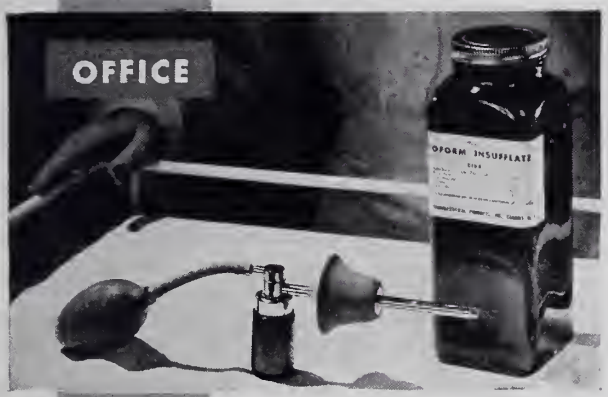

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Modern Management in Clinical Medicine. By F. Kenneth Albrecht, M. D., S. A. Surgeon, U. S. Public Health Service; Kansas State Tuberculosis Consultant; Formerly Clinical Director, U. S. Marine Hospital, Baltimore, Maryland. Pp. 1238 with 237 illustrations. Baltimore: The Williams and Wilkins Company, 1946. Price $10.00.

This large book with a tremendous quantity of factual material is almost a medical encyclopedia. It is obviously a reference work rather than a text book, to which the practitioner of medicine may turn for a brief summary of symptoms and the differential diagnosis of many diseases plus succinct but more comprehensive discussions of therapy. No one could put this much material between covers without certain errors as on page 70, "gastric ulcer is more common in women." Actually duodenal ulcer, if one speaks of chronic ulcers, which are the important peptic ulcers, are more common in women. The classification for heart disease is that of some years back, not the present one. "Coronary heart disease" page 259, is the unjustifiable employment of an anatomic term for an etiologic diagnosis and does not conform to the American Heart Association terminology.

Special outlines are given for case study at the beginning of several chapters. This is proper perhaps but makes for considerable repetition. The chapter on geriatrics and that on Common Procedures for Care of the Ambulatory Patient also make for repetition, but repetition is obvious elsewhere in the book, too. The emphasis on venereal diseases seems necessary, but there seems little place here for color plates depicting prostatic hypertrophy. At times simplicity is so great, as in the discussion of physical signs in the chapter on respiratory disease, that one would think the material was prepared for second year medical students rather than physicians.

One of the best, if not the best, chapter in the book is that on clinical laboratory methods, and the six color plates showing exanthemata in the chapter on infectious diseases are truly superb. There are many other illustrations, most of them very good.

The reviewer dislikes the employment of trade names for common preparations where unnecessary as luminal for phenobarbital for example. Too, the listing of many types of drugs under trade names or manufacturers' labels for treatment of a single symptom of disease may lead to confusion and indecision. Thus to cite, there is little clear cut evidence that the many new antispasmodics under a variety of trade names offer much advantage over atropine save for the occasional patient or occasional symptom.

The author has, all in all, ably completed what he set out to do and in a well organized manner, and probably the practitioner will find this a useful reference work. It is not a book for medical students. The publishers have produced a sturdy well printed, well illustrated volume at a reasonable price. O. O. M.

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WANTED: Association with physician and surgeon for practice in city of 5,000 or more with good hospital facilities and with view of partnership. Wisconsin license, 1943. Now practicing in Illinois. Age 44, protestant. Address replies to No. 50 in care of the Journal.

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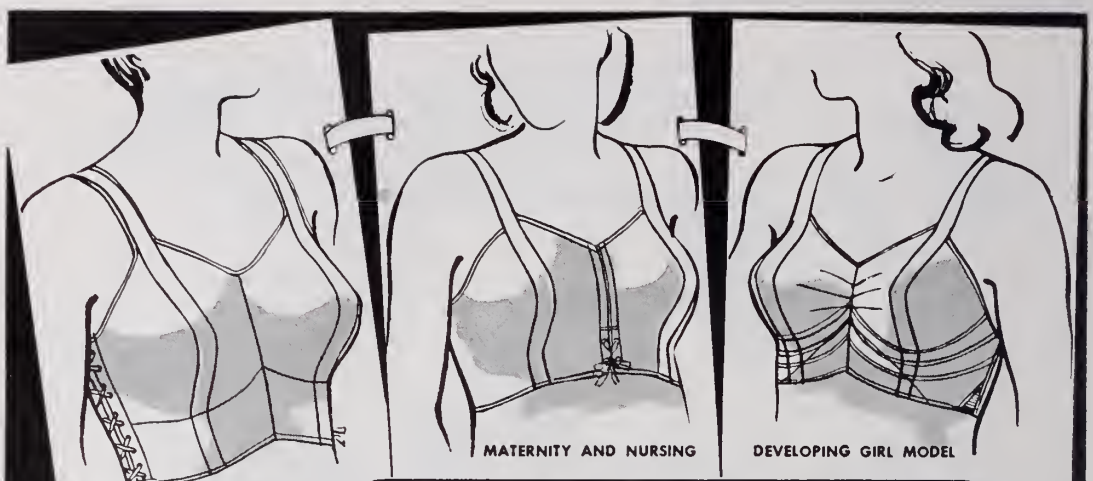

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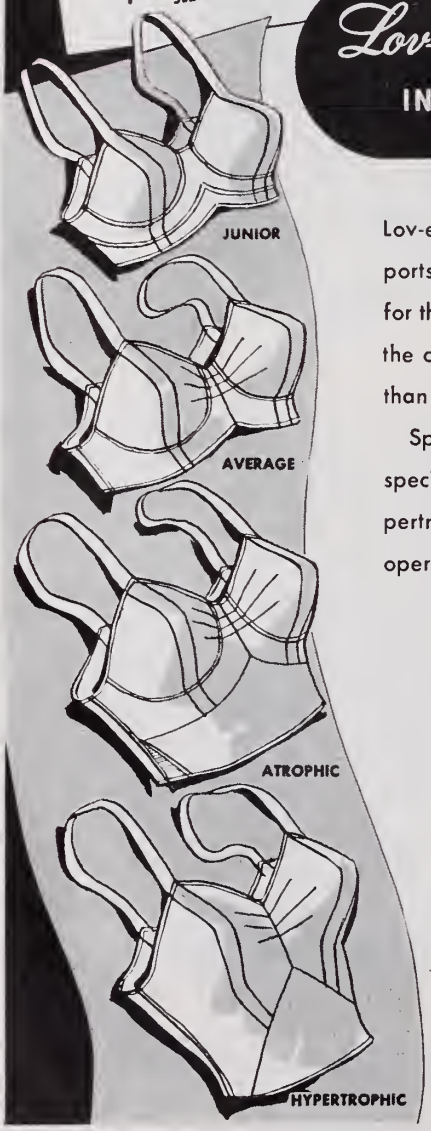

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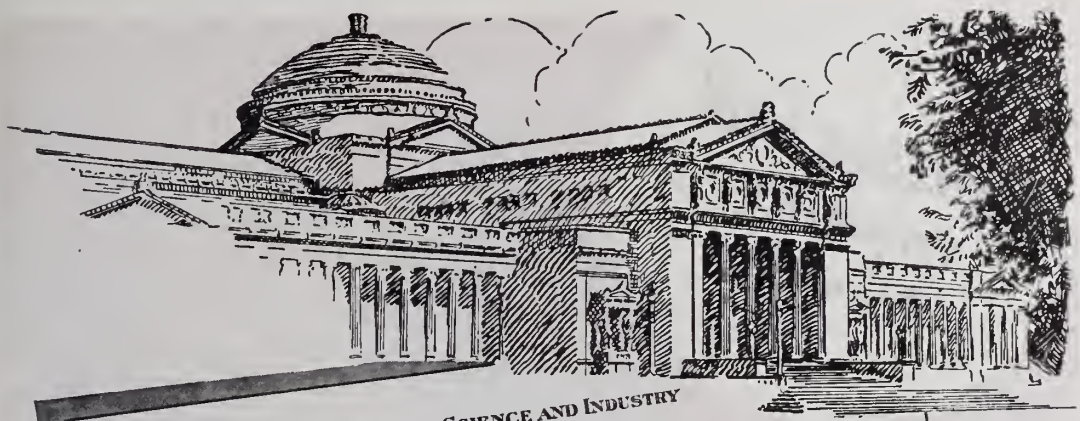

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*Hinsie, Leland E.: The Person in the Body, an Introduction to Psychosomatic Medicine, New York, W.W. Norton & Co., 1945, p. 223.

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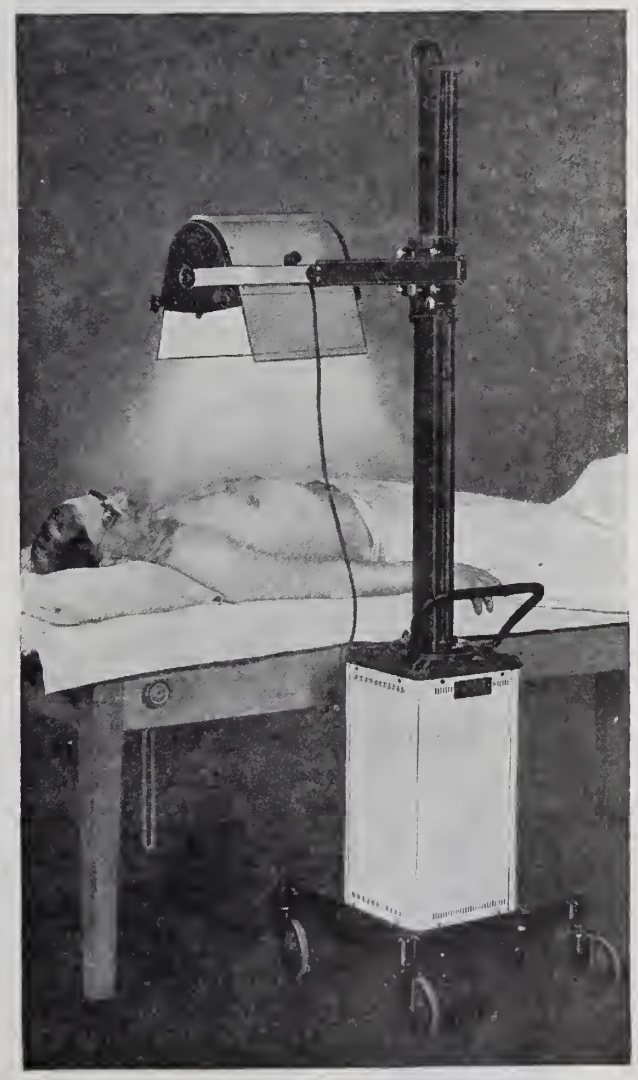

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True Infective Abacterial Pyuria

By EDWARD J. McGINN, M. D.
Marshfield

E. J. McGINN

Doctor McGinn graduated from the Marquette University School of Medicine, Milwaukee, with the class of 1937. Following internship and residency he became associated with the Marshfield Clinic in 1941, and is now attending urologist at the clinic and at St. Joseph's Hospital, Marshfield.

The doctor is a member of the Chicago Urological Society and the North Central Section of the American Urological Association.

PYURIA has always been regarded as an excellent index of the presence of inflammatory disease in the urinary tract. By pyuria we generally mean that leucocytes are present in the urine in excessive numbers. It is generally conceded that so-called normal urine contains some leucocytes. Most authorities agree that ten leucocytes per high power field of centrifuged urine can be considered within normal limits, but these cells should be considered leucocytes and not pus cells. We are not concerned with this type of urine, but rather as stated, those urines which contain excessive amounts of pus cells, sometimes referred to as gross pus.

Furthermore, it almost appears unnecessary to add that one must be sure that the urine examined actually has been collected under circumstances which preclude the possibility of contamination. Many women present themselves with vague urinary complaints and state they have pus in their urine. However, frequently a catheterized urine specimen will be negative for pus cells, and the dysuria is due to a chronic trigonitis or urethritis. Likewise, males may have pyuria associated with frequency or dysuria, and unless a prostatic, or urethral infection is excluded by the two-glass test, the pyuria again is of doubtful significance.

Having once established the presence of infection in the urinary tract, it is of value to determine the type of organism producing the disease, and the presence or absence of any contributing pathology of the urinary tract, such as stone, stasis, or tumor. By no means do I wish to infer that every case of urinary tract infection should have a complete urologic examination, including cystoscopic and urographic studies. The vast majority can be easily and simply cleared with any of our present day antiseptics, such as mandelic acid, sulfonamides, and penicillin. And it appears likely that streptomycin will be a valuable adjunct in the treatment of those urinary tract infections which are caused by the gram-negative bacilli group. However, if two or three courses of treatment fail to sterilize the urine, or if the infection repeatedly recurs, I believe the patient is entitled to a complete urologic survey.

On the other hand, there is no reason why any physician should not determine the type of infecting organism even in simple cases of urinary tract infection. This is especially true in view of the fact that there seems to be some specificity of action of the urinary tract antiseptics against certain organisms. Simple gram staining of the urinary sediment should be done in every case. Examination after gram staining will divide the cases into two groups: the first, those with demonstrable organisms, and the second, those without demonstrable organisms. It will divide the first group further and indicate whether one is dealing with a bacillary or coccal infection and whether the organism is gram-positive or gram-negative.

It is the second group, namely, those in which no demonstrable organism can be found, that I wish to discuss. In the past, all cases of sterile pyuria were thought to be due to tuberculosis. This has been universally taught to most medical students up to the present time. However, in recent years we have come to realize that some cases of sterile or abacterial pyuria belong to a separate and definite disease entity for which there is a specific and spectacular cure. Wildbolz first organized it as a definite and a specific disease in 1933. But it has been in the last five years only that much medical literature regarding sterile pyuria has appeared in this country. And certainly its existence is not appreciated by most physicians.

A typical case report will serve to illustrate the usual course of this disease.

Report of Case

Mrs. R. F. was referred to me in October, 1944. She complained of burning and frequent urination, and extreme dysuria for a period of one year. The symptoms would be worse at times. At that time

there was intense urgency, hematuria, and nocturia eight to ten times. Her history was otherwise unimportant. A general physical examination was negative. Her blood studies and Wassermann were within normal limits. The urine was loaded with pus and blood cells. All stainings of urinary sediment, including special stains for tuberculosis, failed to reveal any organisms. Special cultures for tuberculosis were reported as negative. An excretory urogram revealed excellent function of both kidneys, and no evidence of stasis, stone, tumor, or tuberculosis. A cystoscopy revealed an intensely inflamed bladder with ulcers and inflammatory debris. The entire wall was involved and its capacity was no more than 200 cc. The true significance of the condition was not recognized and the patient was given sulfathiazole by mouth and penicillin intramuscularly in large doses, even though she had previously received this type of therapy elsewhere. These urinary antiseptics did not affect the course of the disease and because of the extreme discomfort the patient was experiencing, continuous bladder lavage with silver nitrate 1–10,000 was instituted. This gave her considerable relief to the point where she was quite comfortable and was dismissed in five days. The improvement by means of silver nitrate bladder lavage suggested the possible diagnosis of interstitial cystitis. However, within two weeks, the patient returned with all her previous symptoms, and if anything, worse. At this point the true significance of the condition was recognized and she was given 0.04 gm. of mapharsen intravenously. Within forty-eight hours after its administration her symptoms dramatically improved. Within one week she was voiding normally, and within two weeks her urine was crystal clear and free from pus. She was given the same dose of mapharsen every five days for three doses and had had no recurrence when last seen in November, 1945.

Etiology

At present, no definite cause can be assigned to true infective abacterial pyuria. The possibilities considered are: (1) bacteria, (2) toxins, (3) syphilis, (4) fungus, and (5) virus. Bacteria, particularly staphylococci, have been considered as a cause, because in a few kidneys removed and examined, Runeberg found staphylococci imprisoned in the cortex and also because staphylococcic urinary tract infection sometimes responds to arsenic treatment. However, most investigators have been unable to find any bacterial causative agent, even after using the most careful and varied bacteriologic procedures. By injecting centrifuged urinary deposits into the pelves of dogs, inflammatory reaction occurs, but no organisms have been isolated.

Toxins from a focus infection have been suggested by Cook as a possible cause, but many of the reported cases have had no demonstrable foci of infection. The general picture of the disease is very much more suggestive of a true infection of the urinary tract.

Syphilis has been thought a possibility because of the specificity of arsenic preparations in its cure. Because diseases are cured by similar therapy is very slender evidence that they have a common cause. Fungus infections of the urinary tract are rare and may show no organisms at times. However, sooner or later their appearance would be noticed, and none of the reported cases afterwards were reported as being caused by fungi.

The first evidence that a disease is caused by an ultramicroscopic virus is necessarily negative. In view of the continued inability of all writers to demonstrate organisms in the urine, true infective abacterial pyuria fulfills this criterion, but so far no positive evidence has been produced.

Pathology

Not much is known regarding the pathology of this condition. One has to rely on the pathologic changes seen in those cases in which a surgical excision had been erroneously carried out due to a mis-diagnosis. A constant feature in all of these cases was that there was no change in the cortex, and the inflammation was limited to the pelves and ureters, and that it was very superficial.

Symptoms

According to the literature, the disease is most common in young male adults. The duration of the disease varies, and if not recognized, the course is prolonged and the symptoms become progressively worse. The onset may be acute or gradual. Symptoms of cystitis or urethritis then present themselves with frequency, urgency, hematuria, and terminal pain. There is usually no disturbance of general health, and the temperature and pulse rate are normal.

Diagnosis

The urine on examination is loaded with pus and may also contain gross blood. Cystoscopy reveals nonspecific inflammatory changes, a reduced vesical capacity, extreme irritability and diffuse involvement of the vesical mucosa with redness, edema, and at times ulceration. Urography frequently discloses dilatation of the pelves, calices, and ureters, which is suggestive of an inflammatory origin, and in other cases the urographic findings are negative. These changes rapidly return to normal when the infection is cured.

The condition most apt to be confused with this is tuberculosis of the urinary tract. However, with present day methods it is possible, I believe, to isolate the tubercle bacilli in every case. In as many as 90 per cent of the cases this can be done by direct microscopic examination of the centrifuged urinary deposit stained by the acidfast method. If this is negative, special cultures may be positive, and a final court of appeal is guinea pig inoculation. If the bacilli cannot be demonstrated in the urine by any of these methods, then the case is not one

of active urinary tuberculosis. Furthermore, Bumpus and Thompson have shown that in 80 per cent of the cases of tuberculosis of the upper urinary tract the genitalia are involved also. In such cases, the clinical findings are: nodular and thickened epididymis, beaded pipestem vasa deferentia, or nodular prostate gland. The diagnosis of tuberculosis should never be made without corroborative evidence other than the apparently sterile pyuria and some suggestive cystoscopic or urographic findings. Subacute prostatitis and interstitial cystitis may occasionally cause some confusion in the differential diagnosis.

Treatment

The disease is resistant to all form of treatment except that which is specific for it. Occasionally the symptoms are relieved by bladder lavage, but eventually, always reappear and can only be completely cured by intravenous injection of an arsenic preparation such as neoarsphenamine or mapharsen. This therapy is entirely empiric, but the results are truly remarkable. The treatment is so specific that it may be used as a very accurate therapeutic test. Only small amounts of the drug need be given and improvement is generally noted after the first injection and always after the second. Three or four treatments are usually recommended. One should bear in mind the usual side reaction following the use of arsenic preparations and it is stated that reactions are more common following the nonspecific use of the drug than in the treatment of syphilis.

Comment

The main concern of this paper is a condition which is becoming better known as times goes on. And the frequency with which it is missed seems ample justification for considering it in detail. If one would keep in mind its possibility, considerable unnecessary discomfort for the patient can be eliminated. Many patients have been submitted to an intensive anti-tuberculosis regimen which entailed an entirely unnecessary economic burden, and others have submitted to unnecessary renal surgery because this simple disease was confused with urinary tuberculosis. It is recommended in cases of sterile pyuria that a therapeutic test with mapharsen be carried out even before the cultural results for tuberculosis are reported. By this means one can possibly effect a dramatic and sudden cure of urinary difficulties much to the patient's gratification.

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Brucellosis at the State of Wisconsin General Hospital*

By EPHRAIM B. COHEN, M. D.

Madison

SINCE 1930 there have been observed at the State of Wisconsin General Hospital in Madison, 53 cases of brucellosis. Criteria for inclusion of cases in this series were a suggestive history and physical examination, plus one or more confirmatory laboratory tests. How the patients met these criteria is seen in table 1. Excluded were patients in whom the diagnosis of brucellosis was made on the basis of agglutination tests or brucellergin reactions alone. In most of these, other diagnoses could be established to account for the clinical picture.

TABLE 1.—*Criteria for Diagnosis*

Suggestive history and physical examination	53 out of 53
Positive blood agglutinations (1 to 80 or more)	49 out of 53
Positive brucellergin skin tests	18 out of 18
Positive opsonocytophagic index	10 out of 10
Positive blood culture	4 out of 29

* Published with the approval of Ovid O. Meyer, M. D., State of Wisconsin General Hospital, Madison.

As might be expected because of the occupational factor in the epidemiology of brucellosis, males predominated over females in the ratio of 39:14. No age group was exempt (table 2).

TABLE 2.—*Sex and Age Incidence of Brucellosis*

Males	39 patients	Range 12 to 69 yrs.	Av. 37 yrs.
Females	14 patients	Range 8 to 73 yrs.	Av. 32 yrs.

Forty-seven patients were assumed to have been exposed to infected material on the basis of occupation, or known consumption of raw milk. Twenty-three patients were farmers, or farmers' dependents, drinking the milk of their own herds. Of the 47 patients assumed to have been exposed, 33 candidly admitted knowledge of the exposure, and 16 stated that they knew their milk was coming from aborting herds.

There has been some discussion in the literature about the familial incidence of brucellosis, though the transmissibility of the disease from man to man

TABLE 3.—*Occupational Distribution of Brucellosis*

Farmers	16
Farmers' dependents	7
Small town restaurant keepers	3
Long distance truckers	3
Veterinary workers	3
Buttermakers	2
Packing plant employees	2
Butchers	2
Assumed exposure	38
Raw milk drinkers, urban	9
Total	47

has been denied.[1] Further, the question whether or not brucellosis may be a factor in unexplained human abortions has not been settled. It is, therefore, interesting that 6 patients gave histories suggestive of attacks of brucellosis occurring simultaneously in one or more other members of their families. Three male patients had wives who aborted one or more times during the husband's illness, and one female patient had three unexplained abortions.

As may be inferred from table 4, it was impossible to draw a sharp line of demarcation between acute and chronic illness in this series. The definition of acuteness and chronicity becomes increasingly difficult when we note that one patient had been bedridden and acutely ill with an almost continuous fever for six months, whereas another patient, whose brucellosis had been in evidence for less than two months, had already had several distinct exacerbations and remissions.

TABLE 4.—*Duration of Illness*

Less than 1 month	7
2– 6 months	22
7–12 months	8
13–24 months	5
25–36 months	2
More than 3 years	9

Paradoxically, during exacerbations many patients had a feeling of well-being approaching euphoria, whereas during remissions they usually suffered weakness, easy fatiguability and mild depression.

Certain symptoms occurred in over 50 per cent of our patients, and define a fairly characteristic clinical profile for brucellosis. All of our patients had had fever, and all complained of weakness or fatigue. Forty-four had had upper respiratory symptoms; 40, chills; 40, weight loss (averaging 21 pounds); 39, muscle or joint pains; 36, drenching night sweats; 33, headaches; 31, gastrointestinal complaints; 27 severe anorexia (22 of these with weight loss of 8 to 40 pounds).

It has been reported[2] that in a series of 47 proved cases of brucellosis, 5 of those presenting upper respiratory symptoms complained of hemoptysis. It is of interest that 5 of the present series also had had hemoptysis. The gastrointestinal complaints were recorded as follows: constipation, 17; abdominal pain, 15; flatulence, 13; jaundice, 9; diarrhea, 7; and melena, 7.

TABLE 5.—*Frequency of Symptoms*

Fever	53
Weakness or fatigue	53
Upper respiratory infection	44
Chills	40
Weight loss	40
Muscle or joint pains	39
Drenching sweats	36
Headache	33
Gastrointestinal complaints	31
Anorexia	27
Skin eruptions	12
Precordial pain	10
Paresthesias	9
Pleuritic pain	6

Physical examination revealed that 32 of the 44 patients complaining of upper respiratory infections actually had upper respiratory tract signs. In contrast to one impression recorded in the literature,[3] the blood pressures averaged a low normal, the average systolic pressure being 123 mm. of Hg., and the average diastolic, 80. In the entire series there was no systolic pressure recorded above 150 mm. of Hg. A palpable liver was found in 38 cases; of these, 22 were stated to be definitely enlarged. The spleen was enlarged in 31 cases. Lymph glands were reported as palpable in 29 cases, and significantly enlarged in 12 of these. The thyroid gland was palpable in 20 instances, and significantly enlarged in 8. The prostate gland was the seat of chronic infection in 8 of the 39 male patients in the series. Of the noteworthy skin manifestations, 6 patients had a pustular dermatitis; 3, rose spots; 2, jaundice; 2, dermatographia, and 1, petechiae. At the height of their illness, 23 patients had fever ranging above 102 F.; 12 from 100 to 102 F.; 18 below 100 F. Pulse and respirations seemed to follow the temperature curve.

Laboratory investigations appeared to refute the contention that a characteristic blood picture accompanies brucellosis. It has been suggested[4] that a macrocytic anemia is seen in this disease. Our hemoglobin determinations averaged 12.7 Gm. and red blood cells 4.5 million. The tendency (table 6) was toward a hypochromic picture, as might be expected in a chronic infectious process.

TABLE 6.—*Hemoglobin and RBC Values*

Hemoglobin		RBC	
14.1–15 grams	18	4.6–5.0 million	30
13.1–14 grams	11	4.1–4.5 million	18
12.1–13 grams	3	3.6–4.0 million	5
11.1–12 grams	6		
10.1–11 grams	7		
9.1–10 grams	7		
8.1– 9 grams	1		

The observation has been made[5] that monocytosis is seen in brucellosis. The highest monocyte count recorded for the group was 22 per cent, suggesting

that it does occur. However, the monocytes averaged only 5 per cent for those patients in whom they were reported, and 4 per cent for the entire series.

TABLE 7.—*Monocytes*

11–22%	4
9–10%	5
7– 8%	8
5– 6%	8
1– 4%	10
Not reported	18

The impression that hyperglycemia may be associated with brucellosis is recorded in a monograph on the disease.[3] The fasting blood sugar determinations for 50 patients in the present series averaged 95 mg. per 100 cc. None was over 120 mg. per 100 cc. Reports of x-ray films of the chest stressed hilar accentuation or adenopathy in 8 of 34 cases, which is consistent with the generalized lymphadenopathy often reported. Electrocardiograms in 10 of 12 cases showed toxic effects on the myocardium. It is of interest to note that erythrocyte sedimentation rates were reported in 4 of the 10 patients with electrocardiographic changes, and all 4 were within normal limits. By the Cutler method, the erythrocyte sedimentation rate in 7 female patients averaged 7 mm. in one hour (upper limit of normal 10 mm.), and in 5 male patients averaged 10 mm. in one hour (upper limit of normal 7 mm.). By a modified Wintrobe method, one reading of 32 mm. in one hour was reported in a male patient (upper limit of normal, 10 mm.).

The therapy of brucellosis at Wisconsin General Hospital has varied with the years. In order of the frequency of their employment, 8 modes of treatment are listed in chart 8, with some indication as to the phase of the disease treated (acute or chronic), and the severity of the febrile reaction during the patient's hospital stay.

There has been no satisfactory follow-up which would indicate the long-range worth of any treatment. As a state institution Wisconsin General Hospital treats patients living up to 300 miles away, most of whom are not heard from after being seen here.

Autopsy reports in brucellosis are rare.[6] The autopsy protocol is therefore reported in the one patient of this series who died while hospitalized.** His serum agglutination titre for Brucella abortus had risen from 1 to 40, to 1 to 1,280 before death. The clinical course was typical of brucellosis, except for several remarkable complications, which may be inferred from the report which follows:

Autopsy No. 35:246; Male; age 22; November 27, 1935.

Gross Description

The body was that of a well nourished, well developed young white man. The periorbital tissues were slightly swollen on the left, and extremely so on the right, with subcutaneous hemorrhage and some maceration of the skin. The whole face was irregularly discolored. There was clotted blood in the nostrils and the upper lip was swollen. Many red spots up to 2 mm. in diameter were seen on the anterior abdominal surface. On the lateral surface of the iliac regions and about the thighs there were larger and darker hemorrhagic areas up to 3 cm. in diameter. There was slight ulceration in the sacral region.

Abdomen: Panniculus adiposus was scanty. The recti were red and well developed. The peritoneal surfaces were smooth, but were extremely congested with many localized areas of subserous hemorrhage. A moderate amount of slightly bloody cloudy fluid was present.

Thorax: The right pleural cavity contained 2 liters of brown fluid, the left, 250 cc. of slightly blood-stained fluid. Fibrous adhesions were present on both sides.

Pericardium: The pericardial cavity contained 80 cc. of clear yellow fluid. The serous surfaces were smooth and glistening.

Heart: Weight, 280 gms. Diameters of the valvular orifices and thickness of the ventricular walls were normal. The muscle was flabby, but its cut surface

** With the permission of the Pathology Department, University of Wisconsin Medical School. Dr. Gorton Ritchie performed the postmortem examination.

TABLE 8.—*Therapy*

	No. of Cases	*Acute**	*Chronic**	*Temperature Range* *Over 102 F.*	*100–102 F.*	*Under 100 F.*
Symptomatic	25	4	25	4	8	13
Sulfonamide	10	8	6	3	4	3
Vaccine	10	6	8	6	2	2
Neoarsphenamine (1934–35)	3	2	2	1	1	1
Killed typhoid I. V.	3	3	2	3	0	0
Quinine (1931–32)	3	3	0	0	3	0
Peptone I.V. (1932)	2	2	1	1	0	1
Penicillin and methionine	2	2	2*	2	0	0

* Where acute and chronic do not equal number of cases treated, some patients were treated when acutely ill in an exacerbation of a chronic illness. The 2 penicillin and methionine treated cases, for example, were seen here in an acute exacerbation of chronic brucellosis.

was normal in appearance. Valves were soft and thin. Coronary arteries were thin-walled and patent.

Right Lung: There was considerable roughening of the pleural surface and many fibrous tags were present. The whole lung was non-crepitant. Cut surface: there was much brownish discoloration and in the upper lobe near the hilum there was a grey-green soft area surrounded by a pale capsule, irregular in shape and about 3 cm. in diameter. The lower lobe was entirely collapsed and brown in color.

Left Lung: There was slight roughening of the pleural surfaces. Cut surface: considerable brown discoloration was present. The smaller bronchi appeared dilated. No definite consolidation could be found.

Hilar Structures: The main vessels were patent. The bronchial mucosa was considerably congested. The lymph nodes were enlarged up to 3 cm. in diameter and their cut surface was firm and slightly medullary in character.

Spleen: Weight, 1,120 gms. The organ was firm and on the medial margin there was an area about 3 cm. long of light color and slightly increased density. Cut surface: the corpuscles were much enlarged, the pulp was light red and fairly firm, and the trabeculae were not increased. The area of increased density was apparently hemorrhagic and sharply demarcated. Within this area there were seen a few irregular pale areas of necrosis.

Liver: Weight, 2,510 gms. The surface was pale, the capsule much thickened and coarsely nodular. Cut surface: there was extremely coarse connective tissue scarring with considerable replacement of parenchyma by connective tissue. The remaining parenchyma appeared for the most part coarse and rather opaque.

Gall Bladder: was slight dilated, with atrophic mucosa and thin wall.

Pancreas: Normal in appearance.

Alimentary Tract: The esophagus was normal in appearance except for edema of the wall. Stomach was normal in appearance. Intestine: Peyer's patches were slightly hyperplastic. The mucosa of the colon had a nodular medullary character and was considerably thickened.

Adrenals: showed no lesion.

Kidneys: Weighed 165 grams each and were grossly normal in appearance.

Ureters: Normal in appearance.

Bladder, prostate, and aorta: No lesion was seen.

Microscopical Report

Heart: Hypertrophy; perivascular fibrosis; hyaline necrosis of many fibers.

Lung: Section 1; Chronic passive congestion with many heart-failure cells; bronchopneumonia. Section 2: intense hemorrhagic pneumonia and localized necrosis, with abscess formation. Section 3: atelectasis with abundant hemosiderin-containing phagocytes.

Bronchial Lymph Node: Acute hyperplastic lymphadenitis with eosinophilia.

Trachea and Bronchi: Acute purulent bronchitis.

Spleen: Fibrosis of pulp which was also crowded with red cells; some corpuscles appeared fibrotic, others hyperplastic; recent anemic infarct.

Liver: Cloudy swelling; slight fatty degeneration; dense and extensive periportal fibrosis with hyperplasia of bile ducts and lymphoid and eosinophile infiltration; liver cell cords were coarse.

Gallbladder: Chronic inflammation and eosinophilia, with acute inflammation superimposed.

Pancreas: Moderate interlobar fibrosis.

Esophagus: Acute ulcerative esophagitis; edema and round-cell infiltration of the wall.

Stomach: Fibrosis of the submucosa; acute inflammation in the wall.

Intestines: The colon showed intense lymphoid, eosinophilic, and plasma cell infiltration of mucosa, and some glands contained a polymorphonuclear exudate; the lymphoid follicles retained their structure, however.

Adrenal: Adenomatous hyperplasia; serous atrophy of the surrounding fat.

Kidney: Cloudy swelling and hydropic degeneration; chronic passive congestion.

Prostate: No lesion.

Aorta: Cholesterol infiltration.

Lymph Nodes: All showed acute and chronic hyperplastic lymphadenitis with eosinophilia.

Pulmonary Artery: Acute inflammation in surrounding tissue.

Anatomical Diagnoses

1. Splenomegaly, with fibrosis of the pulp and a recent infarct.
2. Chronic hepatitis, extreme, with cirrhosis.
3. Generalized acute and chronic hyperplastic lymphadenitis.
4. Acute and chronic gastritis and colitis. Acute ulcerative esophagitis.
5. Lymphoid hyperplasia in the intestines.
6. Subcutaneous and subserous hemorrhage.
7. Gangrene of the right eye.
8. Bronchopneumonia, with abscess formation.
9. Acute fibrinous pleurisy.
10. Chronic passive congestion of the lungs and kidneys.
11. Eosinophilic infiltration of colon, liver, gallbladder, and lymph nodes.

Summary

1. Fifty-three cases of brucellosis seen at Wisconsin General Hospital are reported, with com-

ments on the incidence of certain findings in the history, physical examination, and laboratory investigation.

2. One autopsy protocol is presented in detail.

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CHANGES ANNOUNCED IN CHEST PHYSICIANS PROGRAM

Physicians planning to attend the scientific session of the Wisconsin Chapter of the American College of Chest Physicians, in the Pere Marquette Room of the Hotel Schroeder, Sunday, October 6, will be interested in the following changes made in the program published in the August *Journal:*

A paper on "Esophageal Surgery" will be presented by Minas Joannides, M. D., Chicago, to replace the paper "Diagnosis in Puzzling Lung Conditions," by H. I. Spector, M. D., St. Louis.

The paper "Histoplasmosis and Allied Lung Conditions" which was to be given by Herbert L. Mantz, M. D., Kansas City, will be replaced by a paper entitled "Histoplasmosis—Clinical and Pathologic Manifestations", by Joseph F. Kuzma, M. D., Marquette University Medical School.

An additional paper on "Extrapulmonary Tumors of the Thorax" will be presented by Jerome R. Head, M. D., Chicago.

Discussant for Dr. Paul H. Holzinger's paper on "Manifestations and Modern Management of Pulmonary Suppuration" will be Mischa J. Lustok, M. D., Milwaukee, instead of Leon H. Hirsh, M. D., Milwaukee, as originally announced.

THE MARCH OF MEDICINE

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Appleton	WHBY	1230 kc.	Saturday	11:15 a. m.
Ashland	WATW	1400	Saturday	8:15 a. m.
Calumet, Mich.	WHDF	1400	Saturday	8:15 a. m.
Eau Claire	WEAU	790	Saturday	4:00 p. m.
Escanaba, Mich.	WDBC	1490	Saturday	8:15 a. m.
Green Bay	WTAQ	1360	Friday	3:45 p. m.
Ironwood, Mich.	WJMS	1450	Saturday	8:15 a. m.
La Crosse	WKBH	1410	Thursday	3:00 p. m.
Madison	WIBA	1310	Saturday	10:00 a. m.
Manitowoc	WOMT	1240	Saturday	8:45 a. m.
Marinette	WMAM	570	Saturday	10:45 a. m.
Marquette, Mich.	WDMJ	1340	Saturday	8:15 a. m.
Medford	WIGM	1490	Friday	11:15 a. m.
Milwaukee	WEMP	1340	Saturday	11:30 a. m.
Rice Lake	WJMC	1240	Monday	3:30 p. m.
Stevens Point	WLBL	930	Monday	11:30 a. m.

Notes on Clinical Pathology

Editors—WALTER H. JAESCHKE, M. D., University of Wisconsin, Madison, and
S. B. PESSIN, M. D., Marquette University, Milwaukee

The Interpretation of the Agglutination Test

The agglutination test has long been an excellent and widely used diagnostic aid. In fact, it has proved to be such a reliable procedure that often virtues are ascribed to it which it does not possess. We find that many doctors place too much emphasis on the test, forgetting that it is merely one more piece of clinical evidence and not a diagnosis in itself. Furthermore, one must remember that the agglutination test gives reliable results only in a relatively few diseases, namely, typhoid-paratyphoid fever, tularemia, brucellosis, infectious mononucleosis, and certain rickettsial diseases such as typhus and Rocky Mountain spotted fever. Syphilis should be included in this list, since the flocculation tests of Kahn, Klein, Eagle, and others, which are so widely used, are merely variations of the classical agglutination test.

The following points about the agglutination test should always be borne in mind when interpreting the results:

1. A negative report has no significance. Antibodies do not appear in the blood stream immediately after the onset of the infection. They are rarely found before the tenth to the fourteenth day of the disease. In infectious mononucleosis, for example, one often finds that antibodies do not appear until the patient is convalescent. Occasionally, antibodies may never appear, apparently due to individual idiosyncrasy.
2. A positive agglutination test does not necessarily mean that the patient had that particular illness at the time the blood was taken. Antibodies may persist for months or years after the subsidence of an infection, a phenomenon often seen in patients who have recovered from tularemia, undulant fever, and syphilis. The titer of such residual antibodies depends in part on the original titer at the time of the illness, and in part on the individual. Similarly, vaccination against typhoid, undulant fever, and tularemia, may at times produce a lasting antibody titer. As a general rule, when dealing with vaccinated individuals one can never be sure whether a positive agglutination reaction is due to present infection or past vaccination.
3. Antibodies are specific for a given antigen and not for a disease. Often two bacteria, producing clinically dissimilar illnesses, may have one or more antigens in common. Infections by one such organism will produce antibodies which will bring about the agglutination of any antigenically similar bacteria. Such cross reactions account for a small but important proportion of positive agglutination tests. These reactions are responsible for the false positive "Wassermann" found in malaria and infectious mononucleosis. Tularemia and undulant fever often produce cross reactions for one another. Persons who have received cholera vaccine are reported to possess antibodies against Brucella organisms as a result of the vaccination. A particularly serious cross reaction is seen between E. typhosus or S. paratyphoid B and certain other members of the Salmonella group, since routinely tests are given for only typhoid-paratyphoid antibodies. Infection by another member of the Salmonella group may produce antibodies for these standard organisms and result in an erroneous diagnosis.

How then should one interpret a positive agglutination report? The presence of a high titer of antibodies is usually significant, provided that it fits in with the clinical picture of the patient. The occurrence of a high titer of antibodies in a patient with no other evidence of illness is not enough for diagnosis. In all cases, other evidence should be sought either from the history, in the case of asymptomatic latent syphilis, from the physical examination or from other laboratory tests. Agglutination tests repeated at intervals of five to seven days will show a gradually rising antibody titer in all cases of acute illness. However, patients with a long standing chronic illness may not show such a rise, the maximum titer having been reached before a physician was consulted. By far the best confirmation is the actual isolation of the infecting organism. This is easily done for members of the typhoid-paratyphoid group, less easily for Br. abortus, B. tularensis, and the like. Animal inoculations, when laboratory facilities are available, may be helpful also.

The important point to remember is that the result of the agglutination reaction is only one more piece of data obtained by the physical examination of the patient. If it is significant it should fit harmoniously with the rest of the facts obtained from the history and physical examination. If it does not fit, the significance is always open to question.—E. A. Birge, M. D., *State Laboratory of Hygiene.*

As It Looks to Your State Board of Health

(These timely discussions of health problems are prepared by staff members as a special service to Wisconsin's physicians.)

Hats Off to the Doctors

AMY LOUISE HUNTER

The medical profession can look with pride on the new low 1945 maternal mortality rate of 1.3 for Wisconsin. There were but 81 deaths during the year allocated to causes associated with pregnancy or childbirth. Births have increased in the past decade, so that if 3.7, the rate of 1935, had prevailed, there would have been 235 deaths in these classifications.

The great gain in life conservation reflects not only the intensive educational programs to get expectant mothers under the care of their own physician early in pregnancy, but the vigilance of the medical profession, and the benefits that have come from increased use of hospitals for delivery. In 1945, 91.1 per cent of deliveries were in hospitals, in contrast with 39.8 per cent ten years earlier.

Considering the relatively small increase in hospital beds for maternity care, the interest and special attention of hospital staff physicians to problems of childbirth and good hospital techniques have been important in achieving Wisconsin's new record. Study of maternal deaths by hospital staffs and the institution of consultation as a routine procedure prior to operative deliveries in many hospitals, have undoubtedly been of real value.

Milwaukee continues to show a somewhat higher maternal death rate than the rest of the state, with 1.8 deaths per 1,000 livebirths as compared with 1.2 for Wisconsin, exclusive of the city of Milwaukee.

Although greatest progress has been made in reducing deaths associated with infections, this group accounted for one-third of the total deaths in 1945. Toxemias numbered only one-fifth of the total, also a marked reduction. Hemorrhage as a cause of one-fourth of the deaths became more dominant in the over-all picture. However, the availability of plasma and the more routine use of transfusions suggests probable improvement in this group by another year. Ectopic pregnancies accounted for only 5 deaths as compared with 14 in 1935. Twenty of the 81 deaths followed cesarean sections, with associated sepsis dominating the classifications by cause. Since 1,862 women were delivered by section, the mortality rate in this group remains high. Cesarean deaths appeared in the resident figures of only 12 counties, with La Crosse and Manitowoc each showing 3, and Milwaukee county 5. The balance were distributed 1 each to 9 counties. The incidence of cesarean section continued relatively high in Milwaukee county, where it was the method of delivery in 705 resident births, or 4.9 per cent as compared with 2.5 per cent in the rest of the state.

Mothers expecting first babies seem to report earlier and more frequently to their physicians for routine prenatal supervision. Doctors likewise often pay a little more attention to this group. Although data on former pregnancies is available only for that group of maternal deaths where a delivery occurred (63 of 81), division of this group is of interest, with one-third of the deaths following first pregnancies, one-third following second or third, and one-third following a fourth or later. This suggests that educational programs both for lay and professional persons should direct emphasis to regular care in every pregnancy whether a first, fifth, or later.

As long as unnecessary deaths occur, Wisconsin can improve its record. The state has indeed made excellent progress, but where can we go from here? Let's make new records in 1946 and 1947.—AMY LOUISE HUNTER, M. D., *Chief, Bureau of Maternal and Child Health.*

As It Looks From Colorado

Wisconsin is but one of many state, area, or specialty medical societies. Its perspective is that of a mid-western state. But its problems, at least in part, are also problems elsewhere. These pages are provided periodically for the reactions of medical leadership in other parts of the country.

H. T. SETHMAN

A native of Denver, Mr. Sethman received his degree from the University of Colorado, and worked for over eight years as a newspaper reporter, city editor, and political writer. Most of the year 1923 he spent on a world tour as a tourist conductor.

Since May, 1929, Mr. Sethman, a veteran of World Wars I and II, has been executive secretary of the Colorado State Medical Society and managing editor of the Rocky Mountain Medical Journal.

COLORADANS are proud of their "wide open spaces," their scenery and great distances. On first thought one might not realize that mountain scenery forms a medical economic problem, but on careful study one finds that those tourist-bureau pictures of towering peaks and deep valleys pose the big problem of distributing medical care in this state.

Our cities have their problems, too, no different from yours in the Middle West. But when we put Rural Medical Care in capital letters and appoint a Commission, the average national student immediately pictures farms and villages and small trading areas and thinks of them in longitudinal miles crisscrossed by paved roads. Colorado's mountain miles are tortuous—and some of them are vertical! We have to consider a county bigger than some states (but with only 5,000 population), so split up by mountain ranges that when winter snows close the lesser passes, even the sheriff must travel 200 back-breaking miles through three other counties to go from his county seat to another town in his county only 30 air miles away. And we think of a certain valley supporting 1,000 souls where most of the thousand must travel 45 miles to the nearest doctor—or persuade him to come to them in whatever weather that rugged scenery cares to produce. Or we think of a certain "local" medical society whose 14 members average 48 miles each, every time they meet, and the average *includes* the two doctors in whose office the meeting is held.

It is a tough problem, but we don't want it solved from Washington. The medical profession, locally, is pointing the way to its solution and is insisting that the communities themselves have the potential power to do the job. Colorado's State Medical Society is breaking the problem up into its component parts and is explaining it to those most concerned. They, of course, are the leaders of farm and mining and ranching organizations. We are insisting that they are the ones who must act. They should use the voluntary pre-payment plans now available to ease their way financially and avoid loss of their freedom through national regimentation, yes; but neither voluntary nor compulsory sickness insurance will redistribute physicians. Distribution is their main difficulty, and when they ask why they cannot obtain a doctor for their community we tell them.

For instance: The very nature of modern medical education makes a city man of the young doctor even if he were reared in the country. His pre-medical education is in a medium-sized or large city. His medical school is in a city; so are most hospitals offering good internships and acceptable residencies. Every doctor about to begin practice has had at least seven, perhaps ten years of indoctrination in a certain "way of life." This includes daily contact with scores of other doctors, instant availability of the best in hospitals, medical equipment, laboratories,

and libraries—not to mention the cultural advantages that cities offer to both him and his family.

So the problem is not so purely financial as the do-gooders would have us think, and in this respect we believe Colorado is no different from many other states. In many "one-doctor-towns" where pre-payment is neither desired or needed, lucrative practices go begging while city practitioners struggle to make both ends meet but will not consider moving to small communities. Rather than being financial, the conflict is one of inside plumbing versus the privy, modern family education versus the one-room school, paved streets between office and standardized hospital versus the kitchen table appendectomy by kerosene light, consultant in any specialty at the twist of a telephone dial versus 40 miles of quagmire to the next doctor, who, like as not, is out of town anyway on a call of his own.

We in Colorado see the problem of distributing medical care to rural families as having little to do with their ability or willingness to pay, because they are already both able and willing. We believe the basic trouble is simply the doctor's rightful insistence on decent facilities with which to practice good medicine the way he was taught to practice, plus his insistence on a decent place to live with his family.

Perhaps the threat of Wagner–Murray–Dingell–Pepperism will have been that proverbial darkest part of the night just before the dawn. A few streaks of light are beginning to show. A few rural leaders now admit that their lack of physicians is due in part to their towns' low standards of housing and sanitation. Others publicly state that poor roads form a factor in their inadequate medical care, and add this argument to their push for highway construction. Still others are financing and drawing plans for community health centers and district hospitals and allied facilities to attract doctors, and are not waiting for the slow machinery of the Hill–Burton Bill. Rural health associations are being formed to join the surgical plan of Colorado Medical Service, Inc., the profession-sponsored voluntary non-profit prepayment plan which already covers almost a fourth of Colorado's urban population. These are signs, pointing the way.

Where low income groups have trouble paying the doctor and the hospital, voluntary pre-payment is our proposal as well as yours, and it is welcomed by the general public. But it still is only part of the answer.

Good medical care is just one feature of a high standard of living, and where standards of community living are adequate, so, with rare exceptions, is medical care. Neither federal law nor all the pre-payment plans can move a mountain range or make a doctor enjoy living in its valley. But an inspired and progressive local community can so raise its standard of living that the doctor will move into the valley and admire the mountain range as scenery rather than loathe it as a barrier. The self-seeking politician must be forced, and his horde of well meaning and misguided uplifters persuaded, to give Americans time to solve their medical problems by local evolution rather than national revolution. If thus given reasonable time from without, and supplied with vigor from within, medical guidance of community leadership will finish the job. — H. T. SETHMAN, *Colorado.*

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« « « EDITORIALS » » »

Introducing Dr. Lowell S. Goin, the Guest Editorialist

THE author of this month's guest editorial is one who has strongly opposed the enactment of the Murray–Dingell Bill. He is a doctor but it is not in the doctor's defense or the defense of organized medicine that he has voiced his opposition to this piece of legislation.

Doctor Goin is a native of the United States. His birthplace is Charter Oak, Iowa. He obtained his undergraduate medical education at St. Louis University and did postgraduate study in Germany. He specialized in radiology, is a diplomate of the National Specialty Board, and practices in the special field of radiology. His office is in Los Angeles, California. He is a former president of the American College of Radiology, his term of office having expired June 30, 1946. For a number of years he has ably served as speaker of the House of Delegates of the California Medical Association, and at present is president of the Radiological Society of North America and member of the House of Delegates of the A. M. A.

Although his professional interests lie in the field of medicine, his interest in public welfare forms the broader base of his career. All his addresses and public writings reveal an intimate knowledge of the history of medical progress and its relation to progress in the physical sciences and social and economic developments. It is from this viewpoint that he analyzes the proposals made or implied in pending legislation for better health for Americans and finds that they do not conform to the records of past performance nor to present-day medical knowledge.

It is because he differentiates sharply between Health, Prevention of Disease, and Medical Care of the Sick, and because he analyzes critically the promises made to the public by proponents of the bill, masquerading under the title of a National Health Program, that he is moved to say: "It is wicked to draw unwarranted inferences which seem to brighten the rather dull world of reality."

The Problem of Medical Care

THROUGHOUT the entire history of the practice of medicine, medical care has been administered on a fee-for-service basis. It is a method which has served the people well. The entire profession of medicine may point with pride at its record over the years. Proponents of compulsory health insurance to the contrary notwithstanding, our health record has been an admirable one. We *are* the healthiest people in the world. Life expectancy and longevity have increased steadily; our morbidity and mortality rates decline constantly. The medical profession has given freely of itself to accomplish these miracles and to care for the sick regardless of ability to pay. Those who would have America believe that the poor man who is ill will receive no medical care; that ability to pay is the criterion for health, are either entirely ignorant in the matter, or for purposes of their own, are uttering malicious nonsense.

Nevertheless, it is likely that we must abandon the tried and proved methods of the past, and must find some new way to give medical care to the people. As I have indicated, this is not because we have failed. It is because our science is becoming so vast and so complex that costs necessarily must rise steadily if we are to apply it well, increasing the hardships of too many of the sick. We must consider, then, whether we shall have compulsory or voluntary health insurance.

Physicians are a rather conservative lot of people. They have seen so many miracle drugs, live-forever sera, cancer cures, and tuberculosis remedies come and go, that very justifiably, they turn a rather jaundiced eye on sudden and radical change, and their position becomes even more understandable when one remembers that all too frequently it happens that the most vigorous proponents of a nationalized medical service turn out to be persons who were equally violent in favor of vegetarianism, chiropractic, and quack economics. It is not surprising then, that doctors have been loath to change the time-honored and long-tested methods of the administration of medical care for a new and untried one. But, to their credit be it said, when the physicians of America were persuaded that there was a need for change, and when the entirely reasonable method of pre-payment by voluntary health care plans was shown to offer a means of better distribution of good medical care, they cheerfully assumed the burden of providing such plans for their fellow Americans. The development began about 1939, and since that time there have been created 73 plans in 31 states—a record which cannot be said to reflect indifference to the problem. Over three million people are enrolled, and the membership increased 100 per cent between 1944 and 1945. Voluntary health insurance can solve the problem, and it is my sincere belief that, given reasonable time and freedom from governmental regulation and bureaucratic red-tape, it can and will give more medical care, and much better medical care, to more people than can ever be cared for under a regimented socialistic plan of national health insurance. It is quite true that thus far a not too impressive total of people are covered under such plans; that the coverage offered is not ideal, and that in general, voluntary plans cannot yet claim to have answered the problem. It is equally true that the American republic was evolved by trial and error, that its early history portended failure and disaster, and that evolution is a much slower and less dramatic process than revolution, but that the evolutionary product is likely to be a better and more sound one than that which results from revolution. In a field in which there is only a meager amount of actuarial knowledge, and a minimum of experience, haste must be made slowly, and this is no less true of compulsory than of voluntary health insurance. In a relatively short time, voluntary health plans have made astounding progress, and these plans are in their merest infancy. They offer good medical care, at prices that people can afford, and they give this care without bureaucracy or regimentation, in keeping with our American traditions, and without offense to our American dignity.

Voluntary health insurance can and will go hand in hand with high standards of medical care. Compulsory health insurance will tear down those standards.

Lowell S. Goin, M. D.

THE POLITICAL MACHINE STILL AT WORK

The Answer of Isidore Falk

The August issue of The Journal reprinted with permission an editorial published in the Rocky Mountain Medical Journal concerning the political machine behind the Wagner–Murray–Dingell bill. As noted, this was in type before The Journal's attention was directed to Mr. Falk's reply to that editorial. Readers will be interested in point, counterpoint, and point. It appears that the points have it. But let the reader judge.

FEDERAL SECURITY AGENCY*
SOCIAL SECURITY BOARD
Washington, D. C.

Bureau of Research and Statistics,
Mr. Harvey T. Sethman May 17, 1946.
Managing Editor,
Denver, Colorado.

My dear Mr. Sethman: My attention has been called to the editorial, "The Political Machine Behind the W–M–D Bill," in the April, 1946, issue of the *Rocky Mountain Medical Journal*, pages 289–291. I am writing to protest your publication of this editorial—in large part a personal attack upon me, and based on "a talk by Marjorie Shearon, Ph. D. . . . Research Analyst for the Conference of the Minority, United States Senate." It seems extraordinary that you would publish such an editorial, or would publish it without giving me an opportunity to comment on the alleged facts or to reply simultaneously to this attack on me.

Throughout the editorial, almost every sentence dealing with matters about which I am informed and containing anything susceptible to factual test or verification is erroneous. I select a few statements for specific comment.

1. Your editorial said about me: "False claims regarding his 'cure' for influenza led to his being fired from the University of Chicago and to his grudge against the medical profession."

The fact is that I resigned from the university, at a time and for reasons having no relation to my influenza studies. I never claimed that I had a "cure" for influenza. My first report on influenza etiological studies was made on Dec. 12, 1929. Discussions about leaving the University of Chicago and joining the staff of the Committee on the Costs of Medical Care had begun in the preceding summer; those discussions were definitive by early August, 1929; my resignation (to take effect upon the close of the Autumn Quarter, 1929) was submitted to the Vice President of the university on Sept. 24, 1929, and was accepted by him with regret on the 28th of that month—approximately two and one-half months before my first report on the etiology of influenza. As for having a "grudge against the medical profession," that has no more basis in fact than the rest of the sentence quoted.

2. Your first paragraph about me goes on to say that I then became the Director of Research for the Committee on the Costs of Medical Care; and proceeds with the sentence, "Thus he has become classed as an 'expert' on the basis of data which is out-dated (if ever creditable) and some of which has been re-dated with obvious ulterior motives; . . ." There are several points here and I wish to comment on each of them.

First, I became Associate Director of Study for the Committee, and held that position until the committee completed its five-year program and disbanded. As for becoming an "expert," I had taught and published on public health and related subjects for nearly ten years—at Yale University and at the University of Chicago—before joining the committee's staff in December, 1929. I believe I can fairly state that I was "classed as an expert" before I joined the staff of the committee, and afterward when on the staffs of the Milbank Memorial Fund and of the Social Security Board.

As for the dating of the committee reports, each was dated when it was published, and I have never known of any re-dating of any of those reports.

The credibility of the reports of the Committee on the Costs of Medical Care is attested by the literature on medical economics and the writings of people competent to judge credibility in this field. Also, I invite your attention to the publication procedure, followed by the committee and stated in its publications, which assured that each report of the research staff was carefully reviewed by the committee and published with its approval.

3. Your paragraph about me indicates that I joined the staff of the Social Security Board. It goes on to say "But in 1940, four men ahead of him disappeared and Falk became Director of Research and Statistics—in perfect keeping with his sleight-of-hand manipulations."

The facts are as follows. I joined the staff of the Social Security Board in December, 1936. In 1938, the Director of the Bureau of Research and Statistics resigned and resumed his work as a university professor of law. Before leaving, he advised the Associate Director, who succeeded him as Director, that he recommend me to the board for the position of Assistant Director; he did, and I was appointed to that position. Early in 1940, the Director of the Bureau was asked by the board to become Director of the Bureau of Unemployment Compensation, and he accepted the transfer from the research and statistics bureau to that bureau. At the same conference with the Chairman of the board at which the Director was advised of the board's invitation with respect to him, I received the first information of its invitation to advance me from Assistant Director to Director of Research and Statistics. Neither of my two predecessors in the position of Director has "disappeared";

* Reprinted in full from the *Rocky Mountain Medical Journal*, June, 1946.

both are carrying on their work; and both are my good friends.

As in the case of the few illustrative examples, so with the rest of your editorial. It is based upon misstatements about the Bureau of Research and Statistics, its staff and its work. Your statements about my relations to the 1939 Wagner health bill, to the 1943 Wagner–Murray–Dingell bill, and to Dr. Parran on that bill, etc., are similar distortions.

In light of various remarks in your editorial concerning the work of the Bureau of Research and Statistics, may I add that its work (on old-age, survivors and disability insurance, unemployment compensation, health insurance, public assistance, social security finances, and related subjects), and also that of other bureaus of the Social Security Board, is specifically authorized and required by an Act of Congress.

I do not doubt that you have the right to criticize the Wagner–Murray–Dingell bill if you are opposed to it, and to publish editorial comment on it. I do object, however, to your publishing incorrect statements about me personally, and about the organization with which I am associated and its work. If you had made an effort to check on your information before publication, you could have easily ascertained the facts.

In view of the circulation you have already given the editorial to which I have referred, I ask that you publish this letter in your Journal, directly, so that your readers may be informed of its contents.

Sincerely yours,
(Signed) I. S. Falk, *Director.*

*Editor's Note**—As stated in the letter from Mr. Falk, comments on his career appearing in our April Editorial were requoted from an address by Marjorie Shearon, Ph. D., who was formerly employed in the division of the Social Security Board now headed by Mr. Falk. We publish his letter in full as his own statement of the record of his career.

We would repeat again, however, the well-established fact that since the time Mr. Falk became associated with the Social Security Board the recommendations of that board have offered only one solution to the problem of medical care for the American people—namely, a nation-wide system of compulsory sickness insurance. While in our opinion such compulsion would be a big step toward complete national socialism of the recent and unlamented German type, it is obviously a very small step toward real solution of the admittedly great problems of public health and medical care. This is especially true when we consider that the agency promoting the scheme is financed and empowered by federal law to make continuous studies of medical care and to offer recommendations for improvement in its distribution.

* From the *Rocky Mountain Medical Journal*, June, 1946.

SECRETARY OF WAR APPOINTS MEDICAL ADVISORY COMMITTEE

Secretary of War Robert P. Patterson recently announced appointment of a medical advisory committee to the Secretary of War, to maintain and foster close relations between civilian and Army medicine, and to enable the Army to receive advice on Army medical organization and policies from leaders in civilian medicine.

Members of the new committee are: Dr. Edward D. Churchill of Boston, chairman; Dr. Elliott Cutler, Moseley professor of surgery at Harvard university; Dr. Michael DeBakey of the Tulane University Medical School; Dr. Eli Ginsberg of Columbia University; Dr. William C. Menninger, director of the Menninger Clinic, Topeka, Kansas; Dr. Hugh J. Morgan professor of medicine, Vanderbilt University Medical School, and Dr. Maurice C. Pincoffs, professor of medicine, University of Maryland.

All members of the committee served with the Medical Department of the Army during the war, either as officers or in a civilian capacity, and are intimately familiar with Army medicine. Doctor Churchill, the chairman, was the Army's consultant in surgery in the Mediterranean Theater. He is professor of surgery at Harvard Medical School and president of the American Surgical Association.

During the war, more than 95 per cent of Army doctors were drawn from civilian medicine. Most of these, with the exception of recent graduates of the Army Specialized Training Program, have been released from the Army and have returned to their civilian practices.

Major General Norman T. Kirk, Surgeon General of the Army, previously announced a policy under which distinguished civilian doctors will serve as consultants in their respective specialties in Army general hospitals.

. . . . THE PRESIDENT'S PAGE . . . .

Pioneering in Humanitarianism

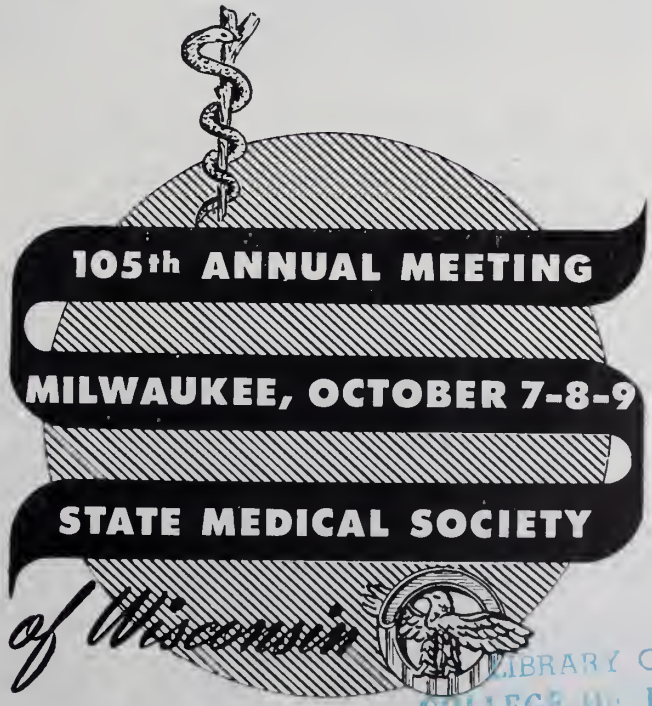
HUMANITARIANISM by law is historically recent. Poor houses and asylums as political establishments were designed as detention places for people of whom the public wished to be relieved. Any thought of care for the unfortunates was decidedly of secondary importance. The same motives can be discerned in the establishment of the state institutions of today that are called charitable. Detention, and the attendant relief of the general public from annoyances, embarrassments, and dangers, give the principal motives for their establishment. Even the schools for the deaf and blind were founded after the same pattern. The criminal, the insane, the tuberculous, are sequestered for purposes of public safety; the syphlitics may receive free treatment at public expense; but the paralytics, the helpless arteriosclerotics, the arthritics, the aged, and others, are subject to the care of local governments without facilities in most cases, and indifference is unhappily general. The deficiencies that exist in our laws covering charitable purposes should be filled by appropriate legislation. Committees of the State Medical Society and the county judges of the state have been studying the difficult problems involved and will ask the legislature for corrective action. For many years, lawmakers, bedeviled by pressure from many groups for appropriations, have done little to improve present establishments. The measure of a civilization is best determined by how it cares for the unfortunate members of society. The ancients, and the moderns too for that matter, have preferred monument building to housing for charitable care. Since we have demonstrated our political ineptitude for solving our present problems, what promise can be offered for efficient political control and operation of the entire medical services of our people? If there exists such a promise it can only be read through the beaming eyes of a psychopathic optimist.

Every individual who is mentally and physically able should care for himself and dependents. Those who are unfit because of mental or physical impairment, should be cared for by society, freely and efficiently without hairsplitting or penny-pinching. And this can be done by integration and amplification of charitable activities without destroying a system of medical service that has, because of the wise policy of its membership, constantly and progressively contributed more toward the happiness of the race than any other human activity that deals with matters physical. Illinois and New Jersey are pioneers in this field of humanitarian legislation. We must not permit Wisconsin to be a laggard.

P. R. Minahan

MILWAUKEE AUDITORIUM WHERE SCIENTIFIC SESSIONS HELD AND EXHIBITS DISPLAYED

Complete Program



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Familiar Annual Meeting Scenes

OF OTHER YEARS

The Annual Meeting of the State Medical Society offers the physicians of Wisconsin an opportunity to renew professional friendships, and acquire new knowledge through a wide variety of activities, including scientific sessions, medical motion pictures, scientific and technical exhibits, and professional round-table discussions or demonstrations.

The following pages describe features of the 1946 Annual Meeting. All indications point to a meeting of superlative value and interest to all those who attend. We hope we will have the pleasure of your presence in Milwaukee, October 7–8–9.

C. D. NEIDHOLD

THE COUNCIL ON SCIENTIFIC WORK— UNDER WHOSE DIRECTION THE SCIENTIFIC SESSIONS OF 1946 HAVE BEEN PREPARED

C. D. NEIDHOLD, Appleton, Chairman
F. D. MURPHY, Milwaukee
C. F. MIDELFORT, La Crosse
E. R. SCHMIDT, Madison
J. M. FREEMAN, Wausau
K. H. DOEGE, Marshfield, ex-officio
W. S. MIDDLETON, Madison, ex-officio
E. J. CAREY, Milwaukee, ex-officio

F. D. MURPHY

K. H. DOEGE

E. J. CAREY

W. S. MIDDLETON

J. M. FREEMAN

E. R. SCHMIDT

Officers

Information

FOR THE YEAR 1946

President_____P. R. MINAHAN, Green Bay
President-Elect_____C. A. DAWSON, River Falls
Secretary_____Mr. C. H. CROWNHART, Madison
Treasurer_____IRA R. SISK, Madison
Speaker, House of Delegates
_____E. C. CARY, Reedsville
Vice-Speaker_____L. O. SIMENSTAD, Osceola

COUNCIL ON SCIENTIFIC WORK

C. D. NIEDHOLD, Chairman, 1947_____Appleton
F. D. MURPHY, 1946_____Milwaukee
E. R. SCHMIDT, 1949_____Madison
J. M. FREEMAN, 1950_____Wausau
C. F. MIDELFORT, 1948_____Eau Claire
E. J. CAREY, ex officio_____Milwaukee
W. S. MIDDLETON, ex officio_____Madison
K. H. DOEGE, ex officio_____Marshfield

MEMBERS OF THE COUNCIL

S. E. GAVIN, Fond du Lac, Chairman

First District_J. F. WILKINSON, Oconomowoc, 1948
Dodge, Jefferson, Waukesha

Second District_____C. E. PECHOUS, Kenosha, 1948
Kenosha, Racine, Walworth

Third District_____C. O. VINGOM, Madison, 1946
Dane, Columbia–Marquette–Adams, Green, Rock, Sauk

Fourth District
_____E. H. SPIEGELBERG, Boscobel, 1946
Crawford, Grant, Iowa, Lafayette, Richland

Fifth District____A. H. HEIDNER, West Bend, 1946
Calumet, Manitowoc, Sheboygan, Washington–Ozaukee

Sixth District_____S. E. GAVIN, Fond du Lac, 1946
Brown–Kewaunee–Door, Fond du Lac, Outagamie, Winnebago

Seventh District_____S. D. BEEBE, Sparta, 1947
Juneau, La Crosse, Monroe, Trempealeau–Jackson–Buffalo, Vernon

Eighth District____A. T. NADEAU, Marinette, 1947
Marinette–Florence, Oconto, Shawano

Ninth District
_____H. H. CHRISTOFFERSON, Colby, 1947
Clark, Green Lake–Waushara, Lincoln, Marathon, Portage, Waupaca, Wood

Tenth District_____R. G. ARVESON, Frederic, 1947
Barron–Washburn–Sawyer–Burnett, Chippewa, Eau Claire–Dunn–Pepin, Pierce–St. Croix, Polk, Rusk

Eleventh District____V. E. EKBLAD, Superior, 1948
Ashland–Bayfield–Iron, Douglas

Twelfth District
_____D. H. WITTE, Milwaukee, 1948
_____R. E. FITZGERALD, Milwaukee, 1948
ROBERT W. BLUMENTHAL, Milwaukee, 1946
Medical Society of Milwaukee County

Thirteenth District__J. D. LEAHY, Park Falls, 1947
Forest, Langlade, Oneida–Vilas, Price–Taylor

CHARLES FIDLER, Milwaukee (Past-Pres.), 1946

BADGES REQUIRED: Admittance to the scientific sessions of the Annual Meeting by badge only. Secure your badge and program at the registration desk in the main arena of the Milwaukee Auditorium. If you lose your badge, another may be secured.

SPECIAL TELEPHONE SERVICE: In order that you may be reached while attending the meeting of the Society, a special telephone will be installed at the Auditorium, and an operator will be on duty when Society functions are in progress. This telephone number is Broadway 6245. Between the hours of 5 p. m. and 8 a. m. calls to you should be sent through Marquette 4131.

RESERVATIONS FOR ROUND-TABLE LUNCHEONS: Because of hotel requirements we must make all luncheon and dinner reservations in advance. Round-table luncheons are limited to twenty-five, and the obstetric manikin luncheons limited to forty. If possible, make your reservations before coming to Milwaukee, but if you have not done so be sure to make your reservations at the time of registration. If you are interested in particular luncheons we suggest reservations prior to the Annual Meeting.

MEDICAL MOTION PICTURES: A full day's program of interesting medical motion pictures has been provided, and will be shown in a room directly across the hall from Plankinton Hall, 2nd Floor, Milwaukee Auditorium, during the scientific programs each morning and afternoon of the Annual Meeting. Detailed information on the films to be shown and the daily schedule will be found on pages 874–875.

VISIT THE EXHIBITS: In keeping with established custom, two half-hour recess periods have been provided each day, during which time those attending the Annual Meeting are urged to visit the scientific and technical exhibits. Without the financial support of the technical exhibits our Annual Meeting program could not be held without a registration fee, and the scientific exhibits are presented at considerable expense to the exhibitors for the benefit of our members. Special demonstrations have been planned for the recess periods by many of the exhibitors, and we urge all those attending the scientific sessions to utilize this part of the program for inspection of new products and results of scientific research.

SESSIONS OF THE HOUSE: All delegates are requested to plan their affairs so that they may attend the opening session of the House of Delegates on Sunday afternoon, October 6, at 5 p. m. in the Banquet Room of the Hotel Schroeder. The second meeting of the House will be at 8 p. m. Sunday, followed by sessions at 5:00 p. m. Monday, and 8 a. m. Tuesday, when the business affairs of the 1946 Annual Meeting will be concluded. Registration is required for all sessions so that an accurate record of attendance can be kept.

HIGH LIGHTS OF PROGRAM

105th ANNUAL MEETING
MILWAUKEE, OCTOBER 7-8-9
STATE MEDICAL SOCIETY of Wisconsin

SUNDAY, OCTOBER 6 . . .

P. M.
5:00 House of Delegates—Banquet Room (Fifth Floor), Hotel Schroeder

MONDAY, OCTOBER 7 . . .

A. M.
7:30 Registration—Main Arena, Milwaukee Auditorium
9:00 General Session—Plankinton Hall, Milwaukee Auditorium
10:00 Recess to View Exhibits
10.30 General Session—Plankinton Hall, Milwaukee Auditorium

P. M.
12:15 Round-Table Luncheons—Hotel Schroeder
2:30 General Session—Plankinton Hall, Milwaukee Auditorium
3:30 Recess to View Exhibits
4:00 General Session—Plankinton Hall, Milwaukee Auditorium
4:30 Repeat Obstetric Manikin Demonstration, Pere Marquette Room (Fifth Floor), Hotel Schroeder
5:00 House of Delegates—Banquet Room (Fifth Floor), Hotel Schroeder
6:45 Veterans Dinner—Crystal Ballroom (Fifth Floor), Hotel Schroeder

TUESDAY, OCTOBER 8 . . .

A. M.
8:00 House of Delegates—Banquet Room (Fifth Floor), Hotel Schroeder
9:00 Section on Hospital Relations—Engelmann Hall, Milwaukee Auditorium
Section on Internal Medicine—Plankinton Hall, Milwaukee Auditorium
Section on Obstetrics and Gynecology—South Juneau Hall, Milwaukee Auditorium
Section on Ophthalmology and Otolaryngology — North Juneau Hall, Milwaukee Auditorium
Section on Pediatrics—North Kilbourn Hall, Milwaukee Auditorium
Section on Radiology—Walker Hall, Milwaukee Auditorium
Section on Surgery—South Kilbourn Hall, Milwaukee Auditorium
10:00 Recess to View Exhibits
10:30 Resumption of Section Meetings
12:15 Round-Table Luncheons—Hotel Schroeder
12:15 Veterans Luncheon—Hotel Pfister (Seventh Floor)
12:15 Hospital Relations Luncheon—Crystal Ballroom, Hotel Schroeder

P. M.
2:30 General Session—Plankinton Hall, Milwaukee Auditorium
3:30 Recess to View Exhibits
4:00 General Session—Plankinton Hall, Milwaukee Auditorium
4:30 Repeat Obstetric Manikin Demonstration, Pere Marquette Room (Fifth Floor), Hotel Schroeder
6:45 Annual Dinner—Crystal Ballroom, Hotel Schroeder

WEDNESDAY, OCTOBER 9 . . .

A. M.
9:00 General Session—Plankinton Hall, Milwaukee Auditorium
10:10 Recess to View Exhibits
10:40 General Session—Plankinton Hall, Milwaukee Auditorium

P. M.
12:15 Round-Table Luncheons—Hotel Schroeder
2:30 General Session—Plankinton Hall, Milwaukee Auditorium
3:30 Recess to View Exhibits
4:00 General Session—Plankinton Hall, Milwaukee Auditorium

M. H. BARKER

J. P. NESSELROD

G. M. CURTIS

GENERAL SESSION

MONDAY—OCTOBER 7

PLANKINTON HALL **MILWAUKEE AUDITORIUM**

9:00– 9:20 **"Management of Dermatitis in General Practice"**
STEPHAN EPSTEIN, Marshfield

9:20– 9:40 **"Diagnosis of Obscure Fevers in General Practice"**
SAMUEL ROSENTHAL, assistant professor of medicine, Marquette University School of Medicine, Milwaukee

9:40–10:00 **"Maintenance of Adequate Respiratory Exchange"**
RALPH M. WATERS, professor of anesthesia, University of Wisconsin Medical School, Madison

10:00–10:30 **RECESS TO VIEW EXHIBITS**

10:30–11:00 **"Infectious Hepatitis"**
M. HERBERT BARKER, assistant professor of medicine, Northwestern University Medical School, Chicago

11:00–11:20 **"Treatment of Malaria"**
MAURICE HARDGROVE, assistant clinical professor, Marquette University School of Medicine, Milwaukee

11:30–12:00 **RECESS TO VIEW EXHIBITS**

12:00– 2:00 **ROUND-TABLE LUNCHEONS AND DEMONSTRATIONS**

2:30– 2:50 **"General Conception of Rh Factor in the Blood"**
WILLIAM D. STOVALL, professor of hygiene, clinical pathologist, University of Wisconsin Medical School, Madison

2:50– 3:10 **"The Rh Factor in Obstetrics"**
JACK A. KLIEGER, clinical instructor, department of obstetrics and gynecology, Marquette University School of Medicine, Milwaukee

3:10– 3:30 **"The Rh Factor in General Practice"**
G. P. LANGENFELD, Theresa

3:30– 4:00 **RECESS TO VIEW EXHIBITS**

4:00– 4:30 **"The Diagnosis and Treatment of Common Ano-Rectal Complaints"**
J. P. NESSELROD, Evanston

4:30– 5:00 **"The Use of Thiouracil and Lugol's Solution in the Preoperative Preparation of the Thyrotoxic Patient"**
GEORGE M. CURTIS, professor of surgery, Ohio State University College of Medicine, Columbus

GENERAL SESSION

TUESDAY—OCTOBER 8

PLANKINTON HALL — MILWAUKEE AUDITORIUM

9:00–11:30 SECTION PROGRAMS

(See pages 871–873 for speakers)

11:30–12:00 RECESS TO VIEW EXHIBITS

12:00– 2:00 ROUND-TABLE LUNCHEONS AND DEMONSTRATIONS

2:30– 3:00 **"The Most Important Therapeutic Measures in the Treatment of Hypertensive Heart Disease"**

PAUL D. WHITE, clinical professor of medicine, Harvard Medical School, Boston

3:00– 3:30 **"The Treatment of Ununited Fractures by Bone Graft Without Tie or Screw Fixation"**

DALLAS B. PHEMISTER, Chicago

3:30– 4:00 RECESS TO VIEW EXHIBITS

4:00– 4:20 **"Hemorrhagic Nephrosis Due to Transfusion Reactions"**

D. MURRAY ANGEVINE, professor of pathology, University of Wisconsin Medical School, Madison

4:20– 4:50 **"The Medical Effects of the Atomic Bomb in Japan"**

A. W. OUGHTERSON, medical and scientific director, American Cancer Society, Inc., New York

THE ANNUAL DINNER

Members of the State Medical Society and their wives and family guests are invited to attend the Annual Dinner in the Crystal Ballroom, Hotel Schroeder, Tuesday, October 8 at 6:45 p. m. Guest speaker of the evening will be Dr. H. H. Shoulders, president of the American Medical Association.

Attendance limited to 400. Tickets on sale at Registration Desk. Dress—Informal.

P. D. WHITE

D. B. PHEMISTER

A. W. OUGHTERSON

GENERAL SESSION

WEDNESDAY—OCTOBER 9

PLANKINTON HALL **MILWAUKEE AUDITORIUM**

9:00– 9:20 "Antibiotics in Surgery"
ARTHUR A. SCHAEFER, assistant clinical professor of surgery, Marquette University School of Medicine, Milwaukee

9:20– 9:40 "Antibiotics in Venereal Disease"
CAPTAIN L. L. VESEEN, M. C., formerly attending urologist at Passavant Memorial Hospital and Cook County Hospital, Chicago

9:40–10:10 "Antibiotics"
WESLEY W. SPINK, professor of medicine, University of Minnesota Medical School, Minneapolis

10:10–10:40 RECESS TO VIEW EXHIBITS

10:40–11:10 "Trench Foot, Immersion Foot and Frostbite"
H. B. SHUMACKER, JR., assistant professor of surgery, Johns Hopkins University School of Medicine, Baltimore

11:10–11:25 Address of Immediate Past President, P. R. Minahan

11:25–11:40 Address of Incoming President, C. A. Dawson

11:40–12:00 RECESS TO VIEW EXHIBITS

12:00– 2:00 ROUND-TABLE LUNCHEONS AND DEMONSTRATIONS

2:30– 3:00 "The Physician and Tuberculosis"
JAY ARTHUR MYERS, professor of medicine, University of Minnesota Medical School, Minneapolis

3:00– 3:30 "What World War II Has Done for Neuropsychiatry"
(Theresa Rogers Memorial Lecture)
W. J. BLECKWENN, professor of neuro-psychiatry, University of Wisconsin Medical School, Madison

3:30– 4:00 RECESS TO VIEW EXHIBITS

4:00– 4:20 "Burns in Naval Personnel at Okinawa"
H. W. CHRISTENSEN, Wausau

4:20– 4:40 "Advances in the Diagnosis and Treatment of Some Pediatric Conditions"
F. R. JANNEY, professor of pediatrics, Marquette University School of Medicine, Milwaukee

4:40– 5:00 "Protrusion of the Intervertebral Disc"
THEODORE C. ERICKSON, associate professor of surgery (neurosurgery), University of Wisconsin Medical School, Madison

L. L. VESEEN

W. W. SPINK

H. B. SHUMACKER, JR.

J. A. MYERS

GUESTS AT SPECIAL FEATURES

A. M. A. PRESIDENT ANNUAL DINNER SPEAKER

Guest speaker at the Annual Dinner, Tuesday, October 8 in the Crystal Ballroom of the Hotel Schroeder will be Dr. H. H. Shoulders, Nashville, Tennessee, president of the American Medical Association. As speaker of the A. M. A. House of Delegates for many years Doctor Shoulders has contributed much to the aggressive leadership which characterizes the national office in Chicago. His interest in both the scientific and economic aspects of medical care prepares him especially for the topic of his address: "The Impact of Scientific Progress on the Economics of Medical Care."

Note: The Annual Dinner is open to wives and family guests of physician members. If your reservation has not been made by the opening of the Annual Meeting purchase your tickets at the registration desk. No reservations can be accepted after Monday noon, October 7, and reservations must be limited to 400 participants.

H. H. SHOULDERS

GENERAL LULL FEATURE OF VETERAN'S DINNER

Major General George F. Lull, recently named as General Manager and Secretary of the American Medical Association, will be the guest speaker at the special dinner for veteran members on Monday, October 7 in the Crystal Ballroom of the Hotel Schroeder. Doctor Lull served in the Medical Corps of the U. S. Army for thirty-three years, during World War II occupying the post of Deputy Surgeon General, as Chief of the Personnel Service. His address will be devoted to "Reconversion Problems in Medicine."

Note: All veterans of World War II are invited as guests of the State Society. Invitations have been sent all those whose addresses are known to the Secretary's Office. If you are a veteran of World War II and have not yet sent in your reservation for this dinner please do so prior to September 20. No reservations can be accepted at a later date.

G. F. LULL

COLONEL J. C. HARDING TO ADDRESS HOSPITAL RELATIONS LUNCHEON

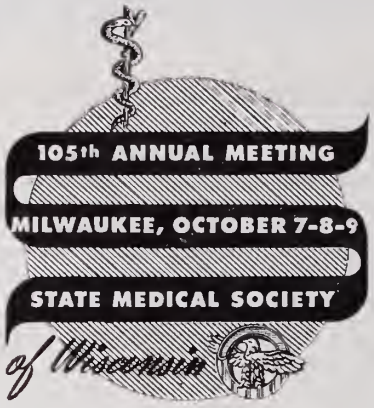
The problems of hospitalized care of veterans will be discussed by Colonel J. C. Harding, Veterans Administration, Washington, at the Hospital Relations Luncheon, to be held in the Crystal Ballroom of the Hotel Schroeder on Tuesday noon, October 8. Colonel Harding, in his close association with General P. R. Hawley, is in a position to speak with authority on policies of the veterans administration in respect to medical care and hospitalization of all veterans. During the past several months Colonel Harding has had numerous contacts with Wisconsin physicians in framing the contract governing the care of veterans in Wisconsin.

Note: While there is no limit set on the attendance at this luncheon it is essential that advance reservations be received prior to October 8. No reservations can be accepted after noon of Monday, October 7. Those who have not made their reservations prior to their attendance at the Annual Meeting can secure tickets at the registration desk.

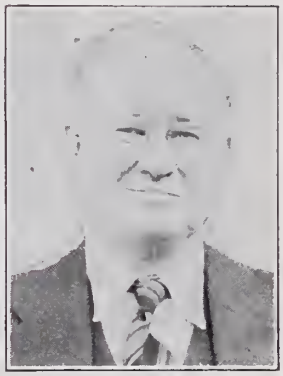
J. C. HARDING

GUEST SPEAKERS—SECTION PROGRAMS

C. V. MOORE
Internal Medicine



MR. K. A. KIRKPATRICK
Hospital Relations



O. H. ROBERTSON
Internal Medicine

OTHER GUEST SPEAKERS
PICTURED ELSEWHERE

P. D. White (Internal Med.)_page 871
J. P. Greenhill (OB & Gyn.)_page 872
G. M. Curtis (Surgery)_____page 873

R. L. J. KENNEDY
Pediatrics

F. A. FIGI
Opthalmology & Otolaryngology

F. N. KNAPP
Opthalmology & Otolaryngology

C. A. ALDRICH
Pediatrics

SECTION SCIENTIFIC SESSIONS

HOSPITAL RELATIONS

Russell M. Kurten, Chairman, Racine — Engelmann Hall

Tuesday, October 8

9:00– 9:20 "Visual Education for the Public in Hospital Public Rooms"
ARNOLD S. JACKSON, attending surgeon, Methodist Hospital, Madison

9:20– 9:40 "The Integrated Laboratory"
MR. JOSEPH NORBY, administrator, Columbia Hospital, Milwaukee

9:40–10:00 "Hospital Postgraduate Education"
OVID O. MEYER, professor of medicine, University of Wisconsin Medical School, Madison

10:00–10:30 RECESS TO VIEW EXHIBITS

10:30–10:45 "The Impact of Hospital and Prepaid Surgical and Obstetrical Insurance on the Private Hospital"
REV. W. G. SODT, administrator, Milwaukee Hospital, Milwaukee

10:45–11:00 "The Public in the Nursing Problem"
SISTER M. AUGUSTA, dean, College of Nursing, St. Joseph's Hospital, Milwaukee

11:00–11:30 "Today's Health Problems for Farmers"
K. A. KIRKPATRICK, Director of Hospital Service, Minnesota Farm Bureau Federation, St. Paul

HOSPITAL RELATIONS LUNCHEON, Tuesday, October 8, Hotel Schroeder:

Doctor Kurten has arranged to have Colonel J. C. Harding of the Veterans' Administration, Washington, D. C., as guest speaker. Doctor Harding is Assistant Medical Director, serving under General Hawley. The title of Colonel Harding's address at the Hospital Relations Luncheon will be "The Care of the Veteran—Present and Future."

INTERNAL MEDICINE

Chester Kurtz, Chairman, Madison — Plankinton Hall

Tuesday, October 8

9:00– 9:20 "Diphtheritic Heart Disease"
MISCHA J. LUSTOK, Milwaukee

9:20– 9:30 Discussion
WILLIAM S. MIDDLETON, dean, and professor of medicine, University of Wisconsin Medical School, Madison

9:30–10:00 "Use of Folic Acid in Treatment of Macrocytic Anemias"
CARL V. MOORE, professor of medicine, Washington University School of Medicine, St. Louis

10:00–10:30 RECESS TO VIEW EXHIBITS

10:30–11:00 "New Methods for the Control of Acute Respiratory Infections"
O. H. ROBERTSON, professor of medicine, University of Chicago, The School of Medicine, Chicago

11:00 11:30 "The Low Sodium Diet in Congestive Heart Failure"
PAUL D. WHITE, clinical professor of medicine, Harvard Medical School, Boston

OBSTETRICS & GYNECOLOGY

Benjamin E. Urdan, Chairman, Milwaukee — South Juneau Hall

Tuesday, October 8

9:00– 9:20 **"A Five-Year Survey (1941–1945) of Obstetrics at St. Joseph's Hospital"**
H. J. OLSON, associate professor of obstetrics and gynecology, Marquette University School of Medicine, Milwaukee

9:20– 9:30 **Discussion** E. F. SCHNEIDERS, Madison

9:30– 9:50 **"Skin Manifestations of Menstruation"** KURT WIENER, Milwaukee

9:50–10:00 **Discussion**
G. A. COOPER, instructor in dermatology, University of Wisconsin Medical School, Madison

10:00–10:30 RECESS TO VIEW EXHIBITS

10:30–10:50 **"Ectopic Pregnancy"**
MADELINE J. THORNTON, associate professor of obstetrics and gynecology, University of Wisconsin Medical School, Madison

10:50–11:00 **Discussion**
R. S. CRON, head of department of obstetrics and gynecology, Milwaukee University School of Medicine, Milwaukee

11:00–11:30 **"Gynecologic Endocrinology in General Practice"**
J. P. GREENHILL, professor of gynecology, Cook County Graduate School of Medicine, Chicago

OPTHALMOLOGY & OTOLARYNGOLOGY

F. H. Haessler, Chairman, Milwaukee — North Juneau Hall

Tuesday, October 8

9:00– 9:20 **"Some Primary Considerations in Retinal Detachment"**
PETER A. DUEHR, assistant professor of ophthalmology, University of Wisconsin Medical School, Madison

9:20– 9:30 **Discussion**
REINHOLD EBERT, Oshkosh

9:30–10:00 **"Ocular Tuberculosis"**
FRANK N. KNAPP, Duluth, Minnesota

10:00–10:30 RECESS TO VIEW EXHIBITS

10:30–10:50 **"The Importance of Adequate Nasal Ventilation"**
FRANK TRESKOW, Milwaukee

10:50–11:00 **Discussion**
T. L. TOLAN, Milwaukee

11:00–11:30 **"Malignant Tumors of the Pharynx and Larynx"**
FREDERICK A. FIGI, associate professor laryngology, oral and plastic surgery, Mayo Foundation, University of Minnesota Graduate School

PEDIATRICS

John E. Gonce, Jr., Chairman, Madison — North Kilbourn Hall

Tuesday, October 8

9:00– 9:20 **"Recent Advances in Immunization Procedures"**
R. P. SCHOWALTER, assistant clinical professor, Marquette University School of Medicine, Milwaukee

9:20– 9:30 **Discussion**
L. M. SIMONSON, Sheboygan

(Continued opposite page)

RADIOLOGY

E. A. Pohle, Chairman, Madison — Walker Hall

Tuesday, October 8

9:00– 9:20 **"Lesions of the Lungs and Heart"**
RUSSELL F. WILSON, Beloit

9:20– 9:40 **"Technic in Gallbladder, Stomach and Colon Examinations"**
C. F. SHERMAN, Madison

9:40–10:00 **"Radiographic Examination of the Urinary Tract"**
RALPH L. TROUP, Green Bay

10:00–10:30 **RECESS TO VIEW EXHIBITS**

10:30–10:50 **"Fundamental Principles of Radiation Therapy"**
E. A. POHLE, professor of radiology, University of Wisconsin Medical School, Madison, and ELIZABETH CLARK, instructor in radiology, University of Wisconsin Medical School, Madison

10:50–11:10 **"Bone and Joint Conditions Other Than Fractures"**
S. A. MORTON, professor of radiology, Marquette University School of Medicine, Milwaukee

11:10–11:30 **"Fractures, Wrist and Ankle"**
L. V. LITTIG, Madison

SURGERY

Anthony R. Curreri, Chairman, Madison — South Kilbourn Hall

Tuesday, October 8

9:00– 9:20 **"Present Status in the Treatment of Perforated Appendix"**
C. F. CONROY, Milwaukee

9:20– 9:30 **Discussion**
IRWIN SCHULZ, Milwaukee

9:30– 9:50 **"Fracture Disabilities"**
M. L. JONES, Wausau

9:50–10:00 **Discussion**
T. D. SMITH, Neenah

10:00–10:30 **RECESS TO VIEW EXHIBITS**

10:30–10:50 **"Fundamental Principles in the Treatment of Traumatic Wounds"**
FORRESTER RAINE, associate clinical professor of surgery, Marquette University School of Medicine, Milwaukee

10:50–11:00 **Discussion** J. W. MCROBERTS, Sheboygan

11:00–11:20 **"Surgery of the Spleen"**
GEORGE M. CURTIS, professor of surgery, Ohio State University College of Medicine, Columbus

11:20–11:30 **Discussion** F. G. CONNELL, Oshkosh

PEDIATRICS (con't)

9:30–10:00 **"Allowing Young Children to Do Their Stuff"**
C. ANDERSON ALDRICH, professor of pediatrics, Mayo Foundation, Graduate School, University of Minnesota

10:00–10:30 **RECESS TO VIEW EXHIBITS**

10:30–10:50 **"Treatment of Meningitis"**
KENNETH B. MCDONOUGH, assistant professor of pediatrics, University of Wisconsin Medical School, Madison

10:50–11:00 **Discussion**
F. R. JANNEY, professor of pediatrics, Marquette University School of Medicine, Milwaukee

11:00–11:30 **"The Use of Antibiotics in Pediatrics"**
ROGER L. J. KENNEDY, associate professor of pediatrics, Mayo Foundation, University of Minnesota Graduate School

Medical Motion Pictures

H. K. TENNEY

During each of the three days of the Annual Meeting medical motion pictures will be shown in Committee Room D, on the second floor of the Milwaukee Auditorium, directly opposite Plankinton Hall where all general scientific sessions will be held. The medical motion pictures chosen by Dr. H. K. Tenney, Madison, have been selected on the basis of their teaching value. Many of the films selected for the 1946 meeting were first shown at the recent A. M. A. meeting in San Francisco.

MONDAY—OCTOBER 7

Showing of films will follow exact time schedule indicated:

9:00– 9:40	Proctoscopic Cinematography
9:40–10:00	Abnormalities in Gait
10:00–10:30	*Recess to View Exhibits*
10:30–11:00	Accent on Use
11:00–11:30	Hemostasis with Oxidized Cellulose
2:30– 3:30	Animated Hematology
3:30– 4:00	*Recess to View Exhibits*
4:00– 4:15	Repair of Congenital Tracheo-Esophageal Fistula
4:15– 4:30	Early Ambulation

TUESDAY—OCTOBER 8

Showing of films will follow exact time schedule indicated:

9:00–10:00	Animated Hematology
10:00–10:30	*Recess to View Exhibits*
10:30–11:00	Hemostasis with Oxidized Cellulose
11:00–11:30	Accent on Use
2:30– 3:10	Proctoscopic Cinematography
3:10– 3:30	Early Ambulation
3:30– 4:00	*Recess to View Exhibits*
4:00– 4:15	Repair of Congenital Tracheo-Esophageal Fistula
4:15– 4:30	Abnormalities in Gait

WEDNESDAY—OCTOBER 9

Showing of films will follow exact time schedule indicated.

Wednesday schedule will be the same as Monday's, as shown above.

ANIMATED HEMATOLOGY: Drs. Carroll L. Birch and **Louis R. Limarzi,** University of Illinois College of Medicine, Chicago. (Color, silent) First of a series in hematology, devoted to a review of the macrocytic anemias. It presents first, the physiology of the hemopoietic principle (contained in liver and liver extracts) discussing the effect of this principle on blood cell formation. It includes pictures of patients, photomicrographs of blood and bone marrow smears, diagrams, and animated scenes, and outlines the treatment of pernicious anemia, tropical sprue, cirrhosis of the liver, and aplastic anemia.

Note: In choosing this film for showing Doctor Tenney has emphasized the teaching value of seeing the film from the very beginning, so it is suggested that all those viewing this film plan their schedule accordingly.

ABNORMALITIES IN GAIT: (Color, silent) This picture is a part of a series produced under the title *Physical Diagnosis,* and distributed through the American Medical Association, portrays the following types of gait: Tabes dorsalis showing ataxic gait, romberg, sign, charcot joint; cerebellar ataxia; spastic paraplegia (showing scissor gait, spastic gait, hyperactive tendon reflexes, ankle clonus, and positive babinski); hemiplegic gait; steppage gait with foot-drop; gait in poliomyelitis; list in a case of sciatic neuralgia; gait in ankylosis of hip and spine; pseudohypertrophic muscular dystrophy; gait of dystonia musculorum deformans; and characteristics of Parkinson's disease.

ACCENT ON USE: National Foundation for Infantile Paralysis, Inc. (Sound) This film was prepared to show the various technics of physical therapy used in the treatment of poliomyelitis. While much of the material is of common knowledge to members of the profession who have directed their attention to this particular medical problem, the film will serve as a good review of methods which might be employed effectively in any hospital in Wisconsin.

EARLY AMBULATION AFTER OPERATION AND RELATED PROCEDURES: Dr. D. J. Leithauser, Detroit, Michigan. (Color, sound) The film presents the principal factors involved in postoperative morbidity. Noxious reflexes to vital organs from the area of trauma are shown by animation. Patients are presented getting out of bed shortly after abdominal operations and their activity gradually increased, control of pulmonary complications by coughing in the standing position is presented. The rapid convalescence after operation is readily recognized.

HEMOSTASIS WITH OXIDIZED CELLULOSE (ABSORBABLE GAUZE AND COTTON): Dr. Virginia Kneeland Frantz, Columbia University College of Physicians and Surgeons, New York. (Silent, color) Motion picture showing a few simple chemical tests of oxidized cellulose in the form of surgical gauze, i. e. solubility, and combination with hemoglobin and with whole blood. The technic of testing absorbable materials in subcutaneous tissue of rats is shown, followed by operative procedures in dogs and human beings in which bleeding is controlled by the hemostatic sponge. Autopsy of the dog four and one-half weeks postoperative is shown.

PROCTOSCOPIC CINEMATOGRAPHY: Drs. J. P. Nesselrod, Evanston, Ill., and **Jay M. Garner,** Winnetka, Ill. (Color, silent) This film begins with the technic of introducing the proctoscope and then shows the appearance of the sigmoid, rectum, and anal canal as seen through the sigmoidoscope. The normal bowel is followed by views of diverticulitis, lymphogranuloma venereum, tuberculous enterocolitis, ulcerative colitis, sigmoidal polyps with fulguration and views during the various stages of healing, recticulum cell lymphosarcoma of the bowel, carcinoma of the bowel, and the appearance of the sigmoid and rectum after a barium enema.

REPAIR OF CONGENITAL TRACHEO-ESOPHAGEAL FISTULA WITH ATRESIA: Dr. Conrad R. Lam, Detroit, Michigan. (Color, silent) The film consists of a pictorial case history of an infant born with atresia of the esophagus and tracheo-esophageal fistula. The chief points in the establishment of the diagnosis are outlined. Operation in this case was carried out on the fifth day of life. The preferred operation of ligation of the fistula and direct anastomosis of the segments of the esophagus within the mediastinum was carried out. The operation is demonstrated by views of the actual procedure and explanatory diagrams. Postoperative care and outpatient followup are depicted.

WISCONSIN STATE MEDICAL GOLF ASSOCIATION

The Wisconsin State Medical Golf Association will hold its annual championship tournament on October 8 at North Hills Country Club. The tournament begins at 1:00 p. m. and the banquet and entertainment follow at 7:00 p. m. at the North Hills Country Club. Those members attending the scientific meeting in the afternoon are invited to come out to the club for the banquet and entertainment at 7:00 p. m.

TEACHING DEMONSTRATIONS

The enthusiastic acceptance of demonstration teaching programs in the fields of obstetrics and gynecology has prompted the Council on Scientific Work to arrange for three Clinical Demonstrations, as described below, in addition to the Obstetrical Manikin Demonstrations which will be presented twice daily on Monday, October 7, and Tuesday, October 8, and once on Wednesday, October 9.

Attendance at the Clinical Demonstrations is limited to 25 and the Obstetrical Demonstrations to 40. No limit of attendance is placed on the repeat obstetrical demonstrations on Monday and Tuesday afternoons.

CLINICAL DEMONSTRATIONS (Parlor A—4th Floor, Hotel Schroeder)

MONDAY, OCTOBER 7, 12:15–2:00 P. M.

CARDIAC DIAGNOSIS: Chester M. Kurtz, associate professor of medicine, University of Wisconsin Medical School.

TUESDAY, OCTOBER 8, 12:15–2:00 P. M.

DISC SYNDROME AND ITS DIAGNOSIS: Theodore C. Erickson, associate professor of surgery (neurosurgery), University of Wisconsin Medical School; and L. W. Paul, associate professor of radiology, University of Wisconsin Medical School.

WEDNESDAY, OCTOBER 9, 12:15–2:00 P. M.

DIAGNOSIS AND TREATMENT OF ALLERGIC DISEASES: T. L. Squier, associate clinical professor of medicine, Marquette University School of Medicine.

OBSTETRICAL MANIKIN DEMONSTRATIONS (Pere Marquette Room—5th Floor, Hotel Schroeder)

[In cooperation with the Bureau of Maternal & Child Health, State Board of Health]

On each of the three days of the Annual Meeting obstetrical manikin demonstrations will be devoted to an explanation of the use of forceps and the indications and contraindications for their use, including the management of occiput posterior and the various methods of treating this presentation. There also will be a discussion of the management of breech presentation and a demonstration of the various methods of delivery as well as version and extraction.

Attendance at the noon luncheon demonstrations limited to 40. No limit on repeat demonstrations on Monday and Tuesday afternoons: 4:30–5:30 (in the Pere Marquette Room of the Hotel Schroeder).

MONDAY, OCTOBER 7

12:15–2:00 p. m. (limit of 40)
4:30–5:30 p. m. (repeat, no limit)

J. E. FITZGERALD

Professor of obstetrics and gynecology, Cook County Graduate School of Medicine, Chicago.

Unable to secure picture at time of publication

TUESDAY, OCTOBER 8

12:15–2:00 p. m. (limit of 40)
4:30–5:30 p. m. (repeat, no limit)

J. P. GREENHILL

Professor of gynecology, Cook County Graduate School of Medicine, Chicago.

J. P. GREENHILL

WEDNESDAY, OCTOBER 9

12:15–2:00 p. m. (limit of 40)
No repeat demonstration

CARLTON WIRTHWEIN

Clinical Instructor of Obstetrics and Gynecology, Marquette University School of Medicine.

CARLTON WIRTHWEIN

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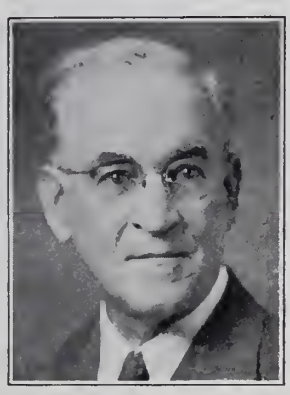
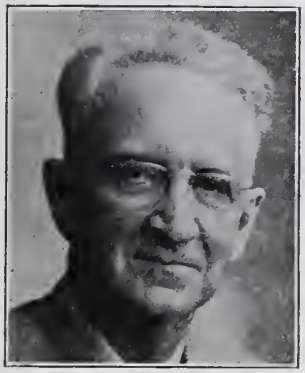


P. R. MINAHAN
Green Bay
President



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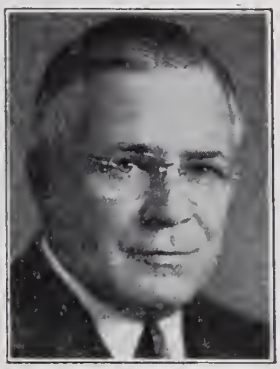

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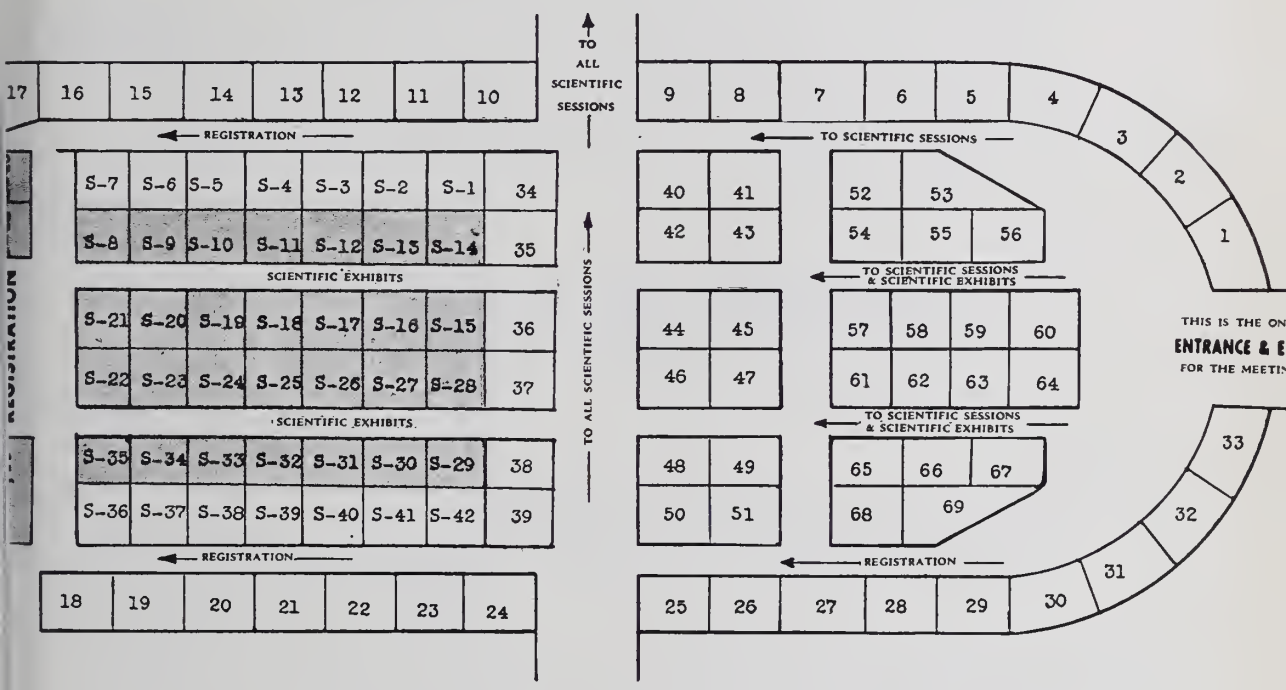
Oconto	R. J. Goggins, Oconto Falls	A. F. Slaney, Oconto Falls
Oneida–Vilas	W. S. Bump, Rhinelander	I. E. Schiek, Rhinelander
Outagamie	G. W. Carlson, Appleton	J. L. Benton, Appleton
Pierce–St. Croix	C. E. McJilton, River Falls	O. H. Epley, New Richmond
Polk	L. O. Simenstad, Osceola	V. C. Kremser, Amery
Portage		W. C. Sheehan, Stevens Point
Price–Taylor	J. D. Leahy, Park Falls	L. E. Nystrum, Medford
Racine	T. C. Hemmingsen, Racine	E. J. Schneller, Racine
Richland	Geo. Parke, Sr., Viola	D. J. Taft, Richland Center
Rock	H. E. Kasten, Beloit	W. T. Clark, Janesville
Rusk	L. M. Lundmark, Ladysmith	Woodruff Smith, Ladysmith
Sauk	Roger Cahoon, Baraboo	J. F. Moon, Baraboo
Shawano	A. A. Cantwell, Shawano	E. E. McCandless, Birnamwood
Sheboygan	C. J. Weber, Sheboygan	P. B. Mason, Sheboygan
Trempealeau–Jackson–Buffalo	R. L. MacCornack, Whitehall	Robert Krohn, Black River Falls
Vernon	R. S. Hirsch, Viroqua	F. F. Gollin, LaFarge
Walworth	E. D. Sorenson, Elkhorn	R. A. Mullen, Burlington
Washington–Ozaukee	Arnold Barr, Port Washington	J. G. Hoffmann, Hartford
Waukesha	H. T. Barnes, Delafield	E. C. Van Valin, Sussex

Society	*Delegate*	*Alternate*
Waupaca	A. M. Christofferson, Waupaca	F. J. Pfeifer, New London
Winnebago	G. R. Anderson, Neenah	W. A. Wagner, Oshkosh
Wood	K. H. Doege, Marshfield	F. X. Pomainville, Wis. Rapids
Section on Internal Medicine	A. W. Bryan, Madison	F. D. Murphy, Milwaukee
Section on Ophthalmology and Otolaryngology	J. K. Trumbo, Wausau	A. H. Pember, Janesville
Section on Orthopedics	R. P. Montgomery, Milwaukee	L. D. Smith, Milwaukee
Section on Radiology	L. V. Littig, Madison	R. F. Wilson, Beloit

THE EXHIBITS ★ SCIENTIFIC ★ TECHNICAL



The entire arena of the Milwaukee Auditorium will be used to house the Scientific and Technical Exhibits described on the following pages. The above map, indicating the location of the various booths, is reproduced to assist physicians in finding specific exhibits in which they are interested.

Special attention is directed to the various recess periods provided each of the three days of the Annual Meeting. A number of special demonstrations have been planned for these particular periods, and physicians are urged to attend. Several Scientific Exhibits will present special demonstrations and lectures during the recess periods. In booths S-8 and S-9 special lip reading demonstrations have been arranged by the Council on Physical Medicine of the A. M. A. in cooperation with Dr. T. L. Tolan, Milwaukee. The display on "Hemolytic Transfusion Reactions, Erythoblastosis and the Erythrocytic Factor, Rh," in booth S-27, will be supplemented by informal explanations and comments of Dr. W. D. Stovall and associates. The two medical schools will present a joint exhibit on applied anatomy in booths S-30, S-31, and S-32, with lectures and dissections during each recess period. Another exhibit featuring demonstrations will be held in booths S-18, S-19, S-20 with members of the Wisconsin Radiologic Society discussing various phases of radiology studies of interest to general practitioners.

Likewise, many of the Technical Exhibits are planning special demonstrations during recess periods, so physicians attending the Annual Meeting are urged to devote a portion of their time to a review of all exhibits presented.

★ SCIENTIFIC EXHIBITS ★

S–8 "Rehabilitation of the Hard of Hearing"

S–9 Council on Physical Medicine of the American Medical Association: This exhibit will feature lip reading demonstrations and the latest types of hearing aids approved by the Council on Physical Medicine.

S–10 "Determination of Prothrombin"

Armand J. Quick, M. D., professor of biochemistry, Marquette University School of Medicine. Equipment required in the test for the determination of prothrombin will be shown, and a description of the preparation of the reagents will be presented. The importance of the determination of prothrombin in clinical medicine, newer findings concerning the nature of prothrombin, the role of this agent in the coagulation mechanism, a classification of the hypoprothrombinemias, and the control of dicumarol therapy will be presented by means of charts.

S–11 "Endocrine Products: Action and Uses"

American Medical Association. The Council on Pharmacy and Chemistry presents an exhibit of the actions, uses, and administration of various endocrine products, including the thyroid gland, parathyroid hormone, adrenal cortex, adrenal medulla, pancreas, estrogenic substances, progestins, androgens and pituitary and gonadotropic substances.

S–12 "Malaria"

American Medical Association. This exhibit describes the mosquitoes which carry malaria and gives in detail the diagnosis of the several types of malaria. Treatment of malaria with quinine, atabrine and quinacrine is presented with tables and dosages.

S–13 "Food Poisoning and Food Borne Infections"

American Medical Association. This exhibit presents a brief survey of the three types of food poisoning: bacterial, chemical, and plants or animals. Attention is given to the food-borne infections.

S–14 "Cancer Detection in General Practice"

American Cancer Society. Emphasis is placed on the role played by the family physician in cancer detection through the use of his hands, eyes and ears, in this exhibit of kodachrome pictures designed exclusively for the medical profession.

S–15 "Early Diagnosis and Treatment of Rheumatoid Arthritis of the Spine"

Wisconsin Rheumatism Association. Members of the association will present patients, together with histories and laboratory findings, to demonstrate early diagnosis and modern treatment of rheumatoid arthritis of the spine. Emphasis is placed on the results obtained from early treatment of the disease.

S–16 "Early Diagnosis of Cervical Carcinoma"

S–17 Charles E. Galloway, M. D., Evanston, Illinois. Various methods of cervical examination; detailed methods of cervical biopsy, both office and hospital; and kodachrome illustrations of other cervical lesions resembling carcinoma in which biopsy is necessary, are shown. This exhibit is prepared especially for the general practitioner, and demonstrates the technic he may use in his own office.

S–18 Section on Radiology

S–19 S–20 During each recess period, in conformance with the wishes of the Council on Scientific Work, radiologists will be present to explain interesting case studies to general practitioners.

S–21 "Studies on Thiouracil"

S. B. Barker, Ph. D., assistant professor of physiology, University of Iowa College of Medicine. This exhibit consists of charts designed to show the effect of thiouracil in decreasing the B.M.R. by interfering with the synthesis of thyroid hormone. Thyroid hypertrophy and hypermia as a result of increased pituitary thyrotrophin secretion will be shown in animals and sections.

S–22 "Physical Medicine"

Curative Workshop of Milwaukee. The exhibit will feature motion pictures describing the physical and occupational therapy treatments employed at the Curative Workshop.

S–23 "The Management of Respiratory Difficulties"

S–24 Ralph M. Waters, M. D., professor of anesthesia, University of Wisconsin Medical School. Anatomical and physical points of importance in understanding the principles of pulmonary ventilation are illustrated. The efficiency of certain methods of treatment and means of artificial ventilation are represented.

S–25 "Unrecognized Tuberculosis in Wisconsin Hospital Admissions"

S–26 Wisconsin Anti-Tuberculosis Association. Included in this exhibit are statistical charts showing reinfection of tuberculosis among hospital personnel, doctors, and nurses. There are also specially illuminated panels dealing with problems of unrecognized tuberculosis in hospital admissions.

S–27 "Hemolytic Transfusion Reactions, Erythroblastosis, and the Erythrocytic Factor, Rh"

W. D. Stovall, M. D., director of the State Laboratory of Hygiene, Madison. This exhibit is a presentation of the relation of the Rh factor to the development of erythroblastosis in unborn children, the method for the use of blood in the treatment of such children, and the part that this factor plays in blood transfusion reactions. A technician will be present in the booth to demonstrate the test.

S–28 Wisconsin Heart Association

S–29 "On Prescription Only"

Wisconsin Pharmaceutical Association. This exhibit will show the professional relationship which exists between pharmacy and medicine. The display will include a group of drugs which according to federal regulations cannot be dispensed without a prescription.

S–30 "Applied Anatomy"

S–31
S–32 Joint presentation by the anatomy departments of Marquette University School of Medicine and the University of Wisconsin Medical School. By means of several dissections, the relationships of the esophagus with the heart and great vessels of the thorax are emphasized, and the left lumbar sympathetic nerves are demonstrated.

S–33 "Accidents on the Farm and How They Hap-
S–34 **pen"**

H. H. Young, M. D. and R. K. Ghormley, Mayo Foundation. Some of the unusual traumatic injuries sustained on the farm are depicted with the aid of series of moulages, and selected rentgenograms of various types of fractures are shown. The exhibit emphasizes frequent causes of farm accidents and stresses means of preventing them.

S–35 "X-Rays for Hospital Admissions"

Wisconsin State Board of Health. An effort will be made to demonstrate the advisability and feasibility of providing each hospital admission with a routine chest x-ray by means of a 70 mm. transportable, automatic, photo-fluorographic unit. For comparison purposes, a 35 mm. view box, a 70 mm. magnifying viewer, and a 4 x 10 view box will be set up.

S–43 "Some Pioneers in Wisconsin Medicine"

S–44 State Historical Society of Wisconsin. This exhibit will feature old instruments, record books, texts, and other material housed in the archives of the State Historical Museum, which it is felt will be of great interest to physicians of the present.

S–45 "Intervertebral Disc Herniation"

S–46 Jackson Clinic, Madison, Arthur C. Stirling, M. D. The exhibit is prepared with special reference to the protruding nucleus pulposus in the lumbar region giving the causes, symptoms, diagnostic tests, and the methods of treatment, conservative and surgical.

★ TECHNICAL EXHIBITS ★

Booth COMPANY AND PRODUCTS

35 Abbott Laboratories, North Chicago, Ill.

You are cordially invited to visit the entirely new exhibit that has been prepared for this meeting. Members of the Abbott professional service staff will welcome an opportunity to discuss newer developments in the antibiotic, anti-convulsant, anesthetic, allergenic, sulfonamide, hematinic, hormone, vitamin and other fields.

20 A. S. Aloe Company, St. Louis, Mo.

The Wisconsin representative of the A. S. Aloe Company will be happy to meet their friends at Booth No. 20. On display will be a cross section of medical and laboratory equipment and supplies. A large selection of new, immediately deliverable army surplus items will be featured.

51 American Hospital Supply Corporation, Chicago, Ill.

Particular attention will be centered upon intravenous solutions and intravenous accessories in the exhibit of the American Hospital Supply Corporation.

6 Ames Company, Incorporated, Elkart, Ind.

Technics for the detection of urine-sugar, albumin, and occult blood will be demonstrated. These will include the clinitest tablet method for the diabetic patient, albutest tablet for protein, and the hematest tablet method for detection of occult blood in body fluids.

Booth COMPANY AND PRODUCTS

S–6 Armour Laboratories, Chicago, Ill.

S–7 Members of the State Medical Society are cordially invited to visit the Armour display, where they may secure copies of the new Armour book, *Function and Malfunction of the Biliary Systems,* as well as several other publications issued by this company.

48 Ayerst, McKenna & Harrison, New York, N. Y.

Among products to be displayed in this booth will be two pertussis preparations, one for immunization and the other for treatment in whooping cough. Another featured item will be "Premarin" which is a preparation of water-soluble equine conjugated estrogens containing sodium estrone sulphate.

14 Barr X-Ray Company, Milwaukee, Wis.

The Mattern line offered by this company includes a varied selection of radiographic units ranging from the portable model, capacity 15 MA, to the dynagraph model, capacity 200 MA at 100 KV, equipped with the rotating anode tube. Therapy units, delivering up to 150 KV, are also offered by this company.

43 Benson Optical Company, Inc., Minneapolis, Minn.

Representatives of the Benson Optical Company, with laboratories located throughout the state, will be happy to answer inquiries regarding the company's contact lens dispensing service and facilities for fitting plastic artificial eyes.

Booth COMPANY AND PRODUCTS

13 Bidwell Better Limbs, Milwaukee, Wis.

A large variety of surgical and prosthetic appliances will be displayed in our booth.

52 Bilhuber–Knoll Corporation, Orange, N. J.

Such medicinal chemicals as Dilandid, analgesic and cough sedative; Metrazol, analeptic and antianoxant; Theocalcin, myocardial stimulant and diuretic, and others will be presented for your inspection.

S–40 Blakiston Company, Philadelphia, Pa.

We will have available for your inspection a new work on *Diseases of the Retina* by Herman Elwyn; several books which record medical progress since the war; and Fleming's *Penicillin, Its Practical Application.* Physicians are invited to consult company representatives regarding these and other new publications which will be off the presses soon.

39 Borden Company, New York, New York

Among the new Borden prescription products to be displayed will be a liquid modified milk for infant feeding; a liquid, emulsified soy food for milk-allergic patients; powdered whole milk; and powdered protein and lactic acid milks for special infant feeding cases.

15 Brooks Appliance Company, Chicago, Ill.

We will exhibit proctological instruments, needles and syringes, surgical belts, elastic hosiery, combination pressure bandages, and various other types of surgical dressings. Representatives will demonstrate the use of the different items.

40 Burroughs Wellcome and Company, New York, N. Y.

Of particular interest in this exhibit of pharmaceuticals and chemicals are Globin Insulin, for diabetic control; Dexin, a non-fermentable milk modifier; and Lubafax surgical lubricant, one of our newest preparations.

25 Camel Cigarettes, New York, N. Y.

26 Camel cigarettes will present a full-color review of their recent medical research and survey on smoking. Another panel will illustrate the absorption of nicotine in the respiratory tract.

S–1 Cameron Surgical Specialty Company, Chicago, Ill.

This exhibit of products which are now available will include coagular-sigmoidoscope, electro diagnostosets, flexible gastroscopes, bronchoscopes-esophagoscopes-laryngoscopes, and other specialties developed for diagnosis, treatment and surgery.

37 S. H. Camp & Company, Jackson, Mich.

A series of iluminated transparencies, depicting various anatomical conditions before and after application of Camp Scientific Supports, will be displayed. The complete line of merchandise for prenatal, postnatal, visceroptosis, sacro-iliac, hernia and other specific conditions will be shown.

Booth COMPANY AND PRODUCTS

67 Carnation Company, Oconomowoc, Wis.

There will be a display of the various uses of Carnation Vitamin D Evaporated Milk for infant feeding, child feeding, and general diet purposes. The method by which the milk is fortified with Vitamin D will be explained.

63 Ciba Pharmaceutical Products, Inc., Summit, N. J.

Our representatives will be happy to answer any questions you may have about the products to be shown, among which will be Privine HCl, a nasal vasoconstrictor, and Privine jelly, Nupercaine, a spinal anesthetic; and Vioform, a non-irritating antiseptic.

17 Coca-Cola Company, Milwaukee, Wis.

The familiar "Have A Coke" stand will be ready to welcome all physicans attending the meeting.

68 Depuy Manufacturing Company, Warsaw, Inc.

Fracture appliances, S. M. O. bone plates and screws, and the new Depuy screw driver and bone drill will be shown.

5 DeVilbiss Company, Toledo, O.

A complete line of plastic atomizers for the application of nose and throat solutions will be exhibited and demonstrated by our representatives.

S–42 Downs X-Ray Company, Milwaukee, Wis.

Physicians will be interested in our display of x-ray equipment with such special features as automatic circuit to prevent overloading of x-ray tube, compensator for kilo-volt drop, and two shockproof tubes, one for radiography with double focus and one for fluoroscopy.

32 H. G. Fischer & Company, Chicago, Ill.

Featured in this exhibit will be mobile x-ray apparatus suitable for office use and short-wave diathermy equipment guaranteed to be free of radio interference.

1 General Electric X-Ray Corp., Chicago, Ill.

Inasmuch as steel and other materials are still on the critical list, we will not be in a position to exhibit any major equipment. However, company representatives will be happy to greet friends in the medical profession at our booth.

41 Gerber Products Company, Fremont, Mich.

Booklets on infant feeding as well as tested recipes for toddlers and adults on special diets; professional reference cards, giving food values and chemical analyses of Gerber's foods; and samples of several cereal foods will be available at our booth.

11 Grune and Stratton, Inc., New York, N. Y.

Our collection of medical publications contains such books as Urbach's *Skin Diseases, Nutrition and Metabolism,* Benda's "Mongolism and Cretinism," and Kestenbaum's *Clinical Methods of Neuro-Opthalmologic Examination.* An enlarged and revised second edition of Urbach's *Allergy* is now available.

Booth COMPANY AND PRODUCTS

66 Chr. Hansen's Laboratory, Inc., Little Falls, N. Y.

Enlarged photos will illustrate the action of the rennet enzyme in forming soft, fine milk curds. Complimentary packages of "Junket" Rennet Powder and Tablets, as well as literature describing the dietary uses of rennet-custards, will be presented to physicians who register in the booth.

S–5 H. J. Heinz Company, Pittsburgh, Pa.

H. J. Heinz Company will display strained foods for infants and junior foods, especially designed for intermediate feeding. A new publication, *The Nutritive Value of Vegetables* and the 12th edition of *Nutritional Charts, Nutritional Observatory* may be examined in our booth.

S–37 Hoffmann–LaRoche, Inc., Nutley, N. J.

Pharmaceutical prescription specialties will be exhibited. The medical profession's interest in PER-OS-CILLIN, the new oral penicillin; the versatile parasympathetic stimulant Prostigmin; and other products will be satisfied by Hoffmann–LaRoche representatives who will be in attendance to discuss clinical problems.

38 Hurley X-Ray Company, Milwaukee, Wis.

There will be many items of interest in our booth, where products of the Picker X-Ray Corporation and Burdick Corporation will be on display. Our representatives will welcome an opportunity to visit with members of the profession.

22 E. H. Karrer Company, Milwaukee, Wis.

An interesting exhibit comprising physicians, hospitals and medical supplies may be seen by physicians who stop in at our booth.

50 Kelley–Koett Manufacturing Co., Covington, Ky.

Representatives of the company will answer all questions pertaining to the complete radiographic-fluoroscopic installation to be displayed in our booth. This compact equipment combines both radiographic and fluoroscopic facilities with sufficient x-ray energy for any diagnostic requirements.

23 Lakeside Laboratories, Inc., Milwaukee, Wis.
24

The Lakeside exhibit will feature Mercuhydrin, mercurial diuretic. Representatives will be prepared to discuss the latest concepts in the management of cardiac decompensation and the use of Mercuhydrin in new treatment schedules.

S–38 Lea and Febiger, Philadelphia, Pa.

Lea and Febiger will exhibit both new works and new editions of standard books. On view will be such publications as Bell's *Renal Diseases*, Olkon's *Neuro-Psychiatry*, Wesson's *Urologic Roentgenology*, Kovacs' *Electrotherapy*, and Scott and Van Wyck's *Obstetrics and Gynecology*.

Booth COMPANY AND PRODUCTS

16 Lederle Laboratories, Inc., New York, N. Y.

The Lederle exhibit will feature two products, Folvite tablets for the treatment of the macrocytic anemias, and Folvron for patients with iron deficiency anemias.

34 Libby, McNeill and Libby, Chicago, Ill.

Strained and homogenized baby foods are featured at the Libby booth. Physicians are invited to stop and discuss new findings on the availability of iron and ease of digestion of these preparations.

42 Eli Lilly and Company, Indianapolis, Ind.

The Lilly exhibit will feature an interesting demonstration in miniature on penicillin culture. Many products will be on display, and attending representatives will be present to assist visiting physicians in every way possible.

18 J. B. Lippincott Company, Philadelphia, Pa.

We will present for the consideration of physicians the current issue of a new medical journal, *American Practitioner*, designed to shorten the lag between experiment and practice. New books and new editions on display will include *Operative Surgery, Diagnostic Examination of the Eye, Treatment of Bronchial Asthma,* and *Conduction Anesthesia.*

46 M & R Dietetic Laboratories, Inc., Columbus, O.

This exhibit will display Similac, a food for infants deprived either partially or entirely of breast milk. Representatives will appreciate an opportunity to discuss the suggested application for both normal and special feeding cases.

21 Maltine Company, New York, N. Y.

Thromoplastin-Maltine, newest product of our research laboratories, will be displayed. Prepared for diagnostic use only. This product was developed to determine the prothrombin clotting time of blood.

27 Mead Johnson and Company, Evansville, Ind.

Our exhibit will include a new precooked oatmeal cereal, Pabena, as well as such familiar preparations as Dextri-Maltose, Pablum Oleum Percomorphum, and other infant diet materials. Representatives of Mead Johnson and Company will be present to inform visiting physicians of some of the helpful services available to them.

S–2 Medical Protective Company, Fort Wayne, Ind.

The Medical Protective Company's representative will appreciate an opportunity to discuss with you principles of the reciprocal rights and duties of a doctor and patient, and to explain the exacting requirements of adequate liability protection which are peculiar to this field of insurance.

29 Medico–Mart, Incorporated, Milwaukee, Wis.
30

Short wave machines, electro-surgical units, surgical and office lights, ultra-violet lamps, instruments, and professional office furniture will be exhibited.

Booth COMPANY AND PRODUCTS

45 Mellin's Food Co., Boston, Mass.

The Annual Meeting will afford an opportunity for our representatives to exchange ideas with attending physicians relative to the feeding of infants and to the nourishment for adults requiring a restricted diet, as well as the importance of selecting food best adapted to the individual requirements of patients.

61 Mennen Company, Newark, N. J.

The Mennen Company will exhibit their two baby products, baby oil and baby powder, in addition to their fungicidal foot powder, Quinsana. The use of baby oil in maternity hospitals will be stressed.

64 Wm. S. Merrell Company, The, Cincinnati, O.

Members and guests of the Society are invited to visit the Merrell exhibit for a discussion of new therapeutic agents developed by our research laboratories. Qualified representatives will be in attendance at the booth.

3 Philip Morris and Company, Ltd., New York, N. Y.

The method by which diethylene glycol is used as the hygroscopic agent to determine the relative irritability of cigarettes will be demonstrated. Representatives will be happy to discuss researches on this subject, and problems on the physiological effects of smoking.

65 C. V. Mosby Company, St. Louis, Mo.

New books and new editions to be displayed will include Polyak's *The Human Ear in Anatomical Transparencies,* Rubin's *Uterotubal Insufflation,* Key-Conwell's *Fractures, Dislocations and Sprains,* and Tassman's *Eye Manifestations of Internal Diseases.* A cordial invitation is extended to examine these and many other books of interest in our booth.

44 V. Mueller and Company, Chicago, Ill.

New flexible and flexi-rigid gastroscopes; eye, ear, nose and throat equipment; and a complete line of surgeon's instruments will be shown in in this exhibit.

28 National Live Stock and Meat Board, Chicago, Ill.

You are cordially invited to visit our booth and see the completely revised Food Value Charts. The second edition of the Nutrition Yardstick, featuring plastic slides and other informative material on nutrition, will also be on display.

49 A. R. Nechin Company, Chicago, Ill.

On exhibit will be the Jones Waterless Motor-Basal metabolism unit, which records the basal metabolic rate by measuring the time needed for consumption of a pre-determined quantity of oxygen, automatically corrected for barometric and temperature changes.

Booth COMPANY AND PRODUCTS

S–4 Ohio Chemical & Mfg. Co., Chicago, Ill.

We will display our latest operating room table, surgical light, sterilizing equipment, and gas anesthesia and oxygen therapy apparatus. Also featured will be equipment for the administration of aerosol penicillin, and an operating table arm board for intravenous work.

56 Parke, Davis and Company, Detroit, Mich.

Representatives of Parke, Davis and Company, desirous of presenting new advancements to you, will be ready to discuss the nature and employment of new and present products. Displayed will be such preparations as Theelin, Mapharsen, Adrenalin products, and Penicillin.

12 Pengelly X-Ray Company, Milwaukee, Wis.

X-ray equipment and accessory items such as films, chemicals, opaque dyes and radiographic illuminators, will comprise the exhibit presented by the Pengelly X-Ray Company.

54 Pet Milk Sales Corporation, St. Louis, Mo.

55 Specially trained representatives will be in attendance to give information about the production of Pet Milk, its use for infant feeding, and company services available to physicians. Members who visit the exhibit will receive miniature cans.

57 Physicians and Hospitals Supply Co., Inc., Minneapolis, Minn.

58 The Physicians and Hospitals Supply Company extends a cordial invitation to visit this exhibit, consisting of Swedish stainless steel instruments and some new pieces of medical equipment and supplies.

69 Pitman–Moore Company, Indianapolis, Ind.

The theme, "Progress in medicine through Research," will be carried out by illuminated transparencies of scenes in our laboratories. Laboratory representatives will display new products and discuss recent scientific advancements in the field of medicine.

8 Procter and Gamble Co., Ivorydale, O.

Physicians may register at the booth for a copy of our book entitled *Medical Uses of Soap.* Instruction leaflets in handy pad form, designed to save time in answering patients' questions concerning various aspects of home care, will also be available.

53 Roemer Drug Company, Milwaukee, Wis.

A complete line of office equipment and supplies will be on display.

S–39 Sandoz Chemical Works, Inc., New York, N. Y.

For non-narcotic relief of migraine, physicians will be interested in Gynergen (ergotamine tartrate). Recently released is Glysennid for atonic constipation. Also displayed at our booth will be preparations for cardiac conditions and oral calcium therapy, and many other products of our research laboratories.

Booth COMPANY AND PRODUCTS

60 W. B. Saunders Company, Philadelphia, Pa.

New books and new editions to be presented in our exhibit will cover such subjects as *Integrated Practice* in four volumes; *Gastro-enterology* in three volumes; *Allergies* by Cooke; *Atlas of the Pathology of Tropical Diseases* by Ash and Spitz; *Clinical Heart Disease* by Levine; and Beerman and Ingraham's *Syphilology*.

33 Schenley Laboratories, Inc., New York, N. Y.

Our display will be devoted entirely to penicillin and penicillin products. The complete apparatus for penicillin aerosol treatment of respiratory infections by inhalation will be demonstrated, and descriptive literature concerning this treatment method will be supplied on request.

9 Schering Corporation, Bloomfield, N. J.

Recent developments in endocrine therapy, radiographic aids, and pharmaceuticals will be featured. Of particular interest will be Combisul-TD, a sulfonamide combination. Informative literature regarding our products will be provided.

10 G. D. Searle and Company, Chicago, Ill.

In addition to such research products as Aminophyllin, Metamucil, Pavatrine, and Gonadophysin, we will exhibit the new Aminophyllin Supposicones which remain stable at temperatures up to 130 F., but liquefy readily under conditions of use.

19 Sharp and Dohme, Inc., Philadelphia, Pa.

The Sharpe and Dohme display will feature Sulfathalidine, Sulfasuxidine, Lyovac normal human plasma, Prothricin, and Tyroderm. A cordial welcome awaits all visitors.

S–41 Smith–Dorsey Company, Lincoln, Neb.

The Smith–Dorsey exhibit will feature Estrogenic Substances, and representatives from the laboratories will be happy to answer questions concerning this product. Other injectable preparations will also be displayed.

31 Smith, Kline and French Laboratories, Philadelphia, Pa.

Benzedrine Sulfate, N.N.R., introduced ten years ago, and a newer closely related compound, Dexedrine Sulfate, designed for more preponderant central nervous stimulation with a relatively weaker peripheral effect, will form the focal point of attention in this exhibit. Questions concerning possible uses of these products and other preparations may be directed to representatives at the booth.

4 Spencer, Inc., New Haven, Conn.

Spencer individually designed supports for abdomen, back, and breasts will be shown. There will also be a display of supports for patients who have undergone mastectomy, and spinal supports for use following cast removal or as an aid to treatment of protruding disc and other back derangements.

Booth COMPANY AND PRODUCTS

7 E. R. Squibb and Sons, New York, N. Y.

This exhibit shows the blood levels produced by penicillin when administered in either oil and wax or in aqueous solution. Dosages for a variety of diseases are also shown.

S–36 Frederick Stearns and Company, Detroit, Mich.

Neo-Synephrine Hydrochloride products for intranasal, parenteral and ophthalmic use, and Appella Apple Powder for diarrhea will be featured in our booth. Various other preparations may be inspected by those visiting our exhibit.

59 Ulmer Pharmacal Company, Minneapolis, Minn.

Ulmer Pharmacal Company will present a line of pharmaceutical specialties which are not advertised to the laity. All stains and reagents sold by this company are marked for stability.

62 U. S. Standard Products Co., Woodworth, Wis.

Combined pertussis, tetanus and diphtheria; pertussis and diphtheria; and straight pertussis vaccines, as well as a large variety of familiar preparations will be offered for inspection, and representatives will be present to supply information regarding new medical developments.

2 White Laboratories, Incorporated, Newark, N. J.

Cod liver oil concentrate products and other vitamin preparations developed through our laboratory research will be on display. Qualified representatives will make every effort to supply physicians with useful data about products which are exhibited.

36 Winthrop Chemical Company, Inc., New York, N. Y.

Winthrop Chemical Company, Inc. extends a cordial invitation to visit this booth. Representatives will be on hand to discuss the merits of numerous preparations introduced by this firm. Several interesting and informative booklets will be available.

S–3 Wright's Incorporated, Milwaukee, Wis.

In our booth will be a display of eye, ear, nose, and throat equipment, as well as surgical apparatus.

47 Zimmer Manufacturing Company, Warsaw, Ind.

The Zimmer Manufacturing Company takes pleasure in showing fracture equipment equally interesting to the general practitioner, the general surgeon, the industrial surgeon, and the orthopedic surgeon. Our representative in your state for many years will be in attendance.

Annual Reports of the Officers and Committees to the 1946 House of Delegates

1. REPORT OF THE COUNCIL

SINCE the late fall meeting of the House of Delegates in 1945, the Council has held approximately the same number of sessions as in previous years. Since two of these were in the late spring and summer of this year, the minutes for those sessions have not as yet been printed in *The Journal*, but will appear as soon as printing schedules and paper supply permit. It seems only proper to remind the membership, however, that the Council, as the chief executive body of the Society between sessions of the House, has its proceedings fully reported as rapidly as possible. There are few organizations which carry to such lengths efforts to keep the whole membership fully informed.

The Council feels that it has honored the Society in conferring upon Dr. Joseph S. Evans, Madison, and Dr. H. B. Bancroft, Blue Mounds, life membership in this organization of their professional brethren. Both physicians are a credit to medicine and Wisconsin.

Many actions lie within the function of the Council and since they have been or shortly will be fully reported in *The Journal* there seems little need of more than sketching a few of them here. Several special committees have been created, and of them those in the field of Extension of Insurance, School Health, Open Panels, Venereal Diseases, Veterans, Advertising in *The Journal*, and the Editorial Board have been extremely active. The report of the Committee on Veterans was submitted, by direction of the Council, to the special session of the House in 1946. The Council has since acted to implement the program as fully and as effectively as seems possible. Great credit is due the committee for their able discharge of their responsibility, and for the perseverance and ingenuity shown. The Committee on the Extension of Insurance, created by the Council in 1944 pursuant to House instruction, is, in actual effect, a committee of the House and consequently it will report separately.

The Council submits the following reports which have been reviewed by it, and which it believes should be considered by the House as a whole at this time:

ADVISORY COMMITTEE ON ADVERTISING

Harry Beckman; A. L. Tatum; and A. S. Jackson

Recognizing the responsibility of *The Journal* to provide advertising of unquestioned reliability, the Council has appointed an Advisory Committee, to assist the Secretary's Office in determining policies and specific questions of advertising as they arise. The committee has re-affirmed the stand of the Council that only advertising which meets with the standards of A. M. A. Councils shall be advertised in *The Journal*, if such advertising is subject to A. M. A. Council review.

When originally appointed, the committee was asked to consider advertising appearing in various state medical journals affiliated with the Cooperative Medical Advertising Bureau of the American Medical Association (of which *The Wisconsin Medical Journal is a member)* but which had not been Council accepted. The committee unanimously agreed that no such advertising should be accepted by *The Wisconsin Medical Journal.* Since this decision, the rules of CMAB have been strengthened so that all affiliate journals will maintain standards similar to those enunciated by the Advisory Committee on Advertising.

The committee is pleased to render this service to the membership, and is pleased to report that the high quality of advertising in *The Wisconsin Medical Journal* is in keeping with the principles of the American Medical Association and the State Medical Society of Wisconsin.

In concluding this portion of the report, it seems worthy of special note that the Council two years ago revived the practice of having each councilor submit, at the January meeting, a report on the affairs as they exist within his district. This has served to revitalize lagging organizations, and to give each councilor a better understanding of the statewide organization which he serves.

COMMITTEE ON THE SCHOOL HEALTH PROGRAM

Norbert Enzer; H. J. Gramling; L. O. Simenstad; H. A. Sincock; and C. N. Neupert

The work of this committee has to date been in an advisory capacity, as the framework for the revised school health program, under the joint sponsorship of the State Board of Health, the School of Education at the University of Wisconsin, and the Department of Public Instruction, has evolved. In the late spring, the committee met with the director of the school health program, Mr. Warren Southworth, and framed general statements governing the development of a physical examination program in Wisconsin schools. During the ensuing year it is anticipated that the committee will develop specific suggestions as to the content of a school examination program and recommended procedures.

The Committee on the School Health Program has also met with representatives of State Teacher Colleges, and assisted them in the refinement of a student health examination form which it is anticipated will be used in all the state teacher training schools.

The committee has likewise assisted the State Board of Health in formulating an examination form which will be used by the teacher colleges in the examination of teachers.

A problem of considerable concern to educators, which has been referred to the Committee on the School Health Program for counsel, is that of extending interscholastic athletics into the junior high school level. The medical implications of this anticipated sports program will be studied by the committee, and specific recommendations referred to the Council for formal action on the part of the State Medical Society.

Recommendations

As the Committee on the School Health Program directs its attention to the need for a better health evaluation of school students, it becomes increasingly aware that the medical profession has a direct and important responsibility in assisting educators to develop localized examination programs for both students and teachers. The lay public will respect the opinion and recommendations of physicians. The need for improvement is obvious, so it is urged that as this revised program evolves, all county societies lend their sincere efforts to improve the character of health examinations whenever possible. While uniformity is not possible due to diversification of school groups and varying concentration of medical resources, there are certain minimum health standards which should be extended to all school children. During the coming year, the Committee on the School Health Program will call upon localized groups to assist with its program. It is the earnest hope of the committee that all groups contacted will provide the help needed to make this program succeed.

CONFERENCE COMMITTEE ON OPEN PANELS

Russell M. Kurten, chairman; and W. A. Rauch

During the past year the Conference Committee on Open Panels has been called upon to mediate several important disputes between physicians and insurance carriers. Without exception, those involved have been cooperative with the Conference Committee and continued use of the Open Panel has become accepted practice in the large majority of Wisconsin industrial concerns.

As a means of assisting physicians to improve the nature of their medical reports, the Conference Committee has published an important monograph on "Measuring and Recording Joint Function," which it is hoped will be used extensively by Wisconsin physicians.

In the past several months, a new panel has been issued to more than 45,000 employers. Great care has been taken to assure accuracy of the various county panels, and special efforts have been made to include all returning veterans who are interested in participating in the Open Panel program.

Recommendations

The Conference Committee is specifically charged with the responsibility of implementing the Open Panel Agreement, and consequently, has no additional projects to offer by way of recommendations. Its members are pleased to represent the physicians in the program, and it is the hope of the entire Conference Committee that in the year ahead, a greater number of self-insured employers will recognize the value of the Open Panel and adopt its use.

To county societies the Conference Committee urges continued study of local use of the Open Panel to avoid cases of discrimination and avoidance of statutory requirements providing for a "reasonableness" of medical choice on the part of the employee.

COMMITTEE ON WAR RECORDS

R. W. Blumenthal, chairman; A. H. Gundersen; and K. K. Borsack

The compilation of data on the war service of all Wisconsin physicians has been carried on through the Secretary's Office, and it is the plan of the Committee on War Records to compile a complete record for publication as early as possible in 1947. It is hoped that the record will include the service of physicians "on the home front" who assisted the war effort in the many medical activities outside of the armed forces.

During the following months, all veteran members will be asked to supply necessary data, and then the committee will proceed with the assembling of the material, as approved by action of the Council.

Report on Necrology

It is a melancholy responsibility of the Council to report the deaths of the following physicians since the last Annual Meeting. Members of the Society are indicated by boldface type:

Adamski, Alexander W. ---------- Racine
Albright, Charles E. ---------- Milwaukee
Bading, Gerhard A. ---------- Milwaukee
Balkwill, Charles A. ---------- Grafton
Bedley, H. E. ---------- Meridean
Brogan, Henry T. ---------- West Allis
Bryant, Jesse R. ---------- Wausau
Clark, Fay T. ---------- Waupun
Comee, William C. ---------- Neenah
Crane, Leonard H. ---------- Menasha
Cremer, Cornelius H. ---------- Cashton
Daly, Francis P. ---------- Chippewa Falls
Feldt, Robert H. ---------- Milwaukee
Forsbeck, Filip A. ---------- Nashotah
Goebel, Henry J. ---------- Racine
Hartman, Evert C. ---------- Janesville
Hazelton, Walter A. ---------- Hayward
Houck, Mary Piper ---------- La Crosse
Hough, Alexander G. ---------- Beaver Dam
Hunt, Frank O. ---------- Fall River

Johnson, Fred G. ____ Iron River
Keller, Ulysses S. ____ Madison
Kellogg, James R. ____ Portage
Kersten, Norbert M. ____ De Pere
Knauf, Frederick P. ____ Kiel
Kulig, Albert H. ____ Thorp
Lauder, Charles E. ____ Viroqua
Lillie, Osville R. ____ Milwaukee
Lohmiller, Byrlton D. ____ Madison
Ludden, John B. ____ Milwaukee
MacKechnie, Ronald S. ____ Hillsboro
Manning, Walter P. ____ Mellen
Mason, Charles H. ____ Superior
Mauthe, Walter ____ Whitewater
Millman, James C. ____ Platteville
Moraux, Felix E. ____ Green Bay
Morris, R. C. ____ Ft. Atkinson
Murphy, Willis G. ____ Goodman
O'Connell, Joseph ____ Oconomowoc
O'Connor, Walter F. ____ Ladysmith
Packard, Charles D. ____ Rhinelander
Panetti, Ernst J. ____ Milwaukee
Perkins, Chester H. ____ Kenosha
Perlson, Maurice M. ____ Milwaukee
Ragan, William F. ____ Milwaukee
Randall, George R. ____ Wauwatosa
Rice, Rhody W. ____ Stevens Point
Schlossmann, Bernard ____ Milwaukee
Schmidt, Fred M. ____ Eagle
Schnell, William H. ____ Superior
Seeman, William O. ____ La Crosse
Spilberg, Simon B. ____ Milwaukee
Sponner, Robert ____ Milwaukee
Stannard, Gilbert H. ____ Sheboygan
Stubenvoll, Carl E. ____ Shawano
Swenson, George B. ____ Baldwin
Terhorst, John H. ____ Milwaukee
Thompson, Willard L. ____ Lake Mills
Trowbridge, William M. ____ Viroqua
Twohig, Henry E. ____ Fond du Lac
Vosburgh, Wallace H. ____ Denmark
Wallis, Joseph H. ____ Rice Lake
Weber, Erwin P. ____ Milwaukee
Welsh, Sylvester M. ____ Waukesha
Windesheim, Gustave ____ Kenosha
Wright, John C. ____ Stevens Point

2. REPORT OF THE SECRETARY

It has been noted on previous occasions, one of the chief functions of the secretary and headquarters personnel is the implementation of committee functions. These lie in a multitude of fields. It may be the briefing of material desired for study; it may be the preparation of facts gathered by correspondence and research; it is always attendance at and arrangements for such meetings as may be ordered. Thus, in a sense at least, the report of the various committees represents a field of activity in the Society's offices. The complete preparation of *The Journal*, other than scientific material, the handling of advertising, carrying out the instructions of committees, Council, and officers—these and a multitude of other functions are assigned to this office.

The publication of the Medical Forum as an integral part of *The Wisconsin Medical Journal* is an activity of considerable effort. In the year 1945 over 180 items of medical economic significance were prepared for Forum publication. The guest editorials have met with striking response, with papers throughout the state quoting from those that presented matters of newsworthy importance to the general public. During this past year contributions have been developed from officers of other state or specialty medical societies, and these have been of exceptionally high caliber.

There seems to be little need of detailing a multitude of what must seem routine duties to the membership. Among those of greater importance is the maintenance of a current inventory of all physicians in Wisconsin and their practice. This provides a valuable source of information for the returning veteran, and accurate information upon which economic and legislative proposals may be evaluated. The radio program is separately reported, but is mentioned here that it may be realized that the responsibility for maintaining station contact, handling of "fan" inquiries, cutting and distribution of records, and so forth, is another function of the Society's office. Still another of consequence is that of maintaining various informational files from which inquiries of physicians may be answered as promptly as possible, as well as constituting a wealth of information on various medical economic matters.

These and many other matters keep the office thoroughly and sometimes too occupied. Once started on this subject, it becomes difficult to conclude, for each activity is a part of the whole program that has evolved over a period of nearly a quarter of a century. In concluding this brief report, the secretary must state that in all of his services to the Society, never has he been called upon to discharge a function in which he did not personally believe; that he has not and will not assume prerogatives of his own making; and that above all, despite some difficulties that have arisen, his concept is that of a State Medical Society serving the entire profession of the state, and responsible above all to its own self-conceived sense of obligation to the public.

As of August 27, 1946 the membership status may be reported as follows:

1. Fully paid members ____ 2,001
2. Partially paid members ____ 0
3. Members in service paying no dues in 1946, or dues prorated on discharge ____ 698
4. War members who pay no dues ____ 31
5. Resident members who pay $3 ____ 27
6. Life, honorary members, members whose dues were waived because of temporary but serious incapacity ____ 69

Died in Service.

3. REPORTS OF STANDING COMMITTEES

COMMITTEE ON CANCER

W. S. Bump, chairman; L. J. Van Hecke; A. L. Mayfield; H. H. Kleinpell; J. C. Fox; Julius Blom; J. W. McGill; A. R. Curreri; G. E. Eck; D. J. Twohig; L. W. Peterson; G. L. McCormick; and C. J. Weber

Aware of the rising public interest in the importance of cancer as a medical problem, the Committee on Cancer has felt that it has been in a fortunate position because of its association with the reorganized American Cancer Society. This society, made up of laymen and medical and scientific members, has been wisely organized. The laymen who make up a most unselfish group greatly interested in the fight against cancer are responsible for the raising of funds, while the medical and scientific group has the responsibility of determining how these funds are used. The Wisconsin Division of the American Cancer Society is organized much in the same manner. The Committee on Cancer of the State Medical Society has acted as the executive committee and therefore is the body responsible for the functions of the American Cancer Society in Wisconsin.

There is much to be done about cancer in three broad fields: (1) learning about cancer, (2) teaching what is known about cancer, and (3) serving patients with cancer.

In the first category the national organization is doing much, for most of its income is earmarked for research. The Committee on Cancer feels that we in Wisconsin must learn more about the disease in our own state in order to better understand local problems and to better administer the funds available in the state. We should know how many people have cancer in Wisconsin, how early in the course of their disease they seek diagnosis, how early the disease is actually diagnosed, what treatment they receive and with what result. To that end the committee has formulated a special Cancer Report which the American College of Surgeons has approved for use in Wisconsin. It is hoped that full cooperation of all physicians and hospitals will be obtained in this project which can furnish the very information required for promoting the proper type of work against cancer where it is needed.

In regard to teaching, the committee feels that the work of lay education, largely carried on by the Field Army with the aid of physicians, should continue. Probably a study of the Cancer Report, above mentioned, will show in what regions the activity should be intensified. It is most important that the layman who has been aroused to seek early diagnosis and treatment should find a sympathetic, alert physician who is well versed in the modern thought about cancer. To this end the committee has planned a series of comprehensive clinics on cancer by top notch men designed to reach every practicing physician in the state.

And finally concerning the service to the patient, the Committee on Cancer has directed its major attention this past year to the establishment of sound standards for Cancer Detection Clinics. The need for close medical supervision of Cancer Detection Centers is evident, and the Committee on Cancer has established rules providing that any centers operating in Wisconsin must be established upon direct application and approval of the county medical society.

Recommendations

The work of the Committee on Cancer can be made effective only through the wholehearted cooperation of hospital staffs and county medical societies. It is hoped that each county medical society will make the collecting of the data on cancer (using the new records) and the analysis of that data a special yearly project.

In view of the fact that further immediate progress in saving lives from the ravages of cancer partially rests upon skill of the general practitioner in noting "danger signals" before metastasis has occurred, the committee anticipates enthusiastic cooperation from the entire profession through attendance at the special cancer clinics provided for the ensuing year or years.

ADVISORY COMMITTEE ON THE CARE OF CRIPPLED CHILDREN

H. A. Sincock, chairman; J. B. MacLaren; H. L. Greene; W. P. Blount; T. L. Squier; and C. M. Kurtz

In keeping with the purpose of the Advisory Committee on the Care of Crippled Children, special attention has been directed to the varying activities of the Bureau of Handicapped Children. Problems directly referred to the committee by Mr. Frank Powell, director, and Dr. H. Kent Tenney, medical advisor of the Bureau of Handicapped Children, have been discussed.

Major attention this past year has been directed to the development of the rheumatic fever program, and especially the findings of Dr. Chester Kurtz and his associates in the operation of the convalescent home for rheumatic fever victims near Madison. On the basis of reports submitted, the committee is aware of the need for guidance in the development of the program on a state-wide basis. During the ensuing year, it is hoped that the Advisory Committee on the Care of Crippled Children can provide a set of minimum standards which should be used by county medical societies in the establishment of convalescent homes for rheumatic fever patients in Wisconsin.

Special attention has been directed to pressures applied to the Bureau of Handicapped Children to provide funds, supposedly made available through Washington agencies, for the purchase of hearing aids to all those applying for such assistance. The committee has been apprised of this problem, and has tentatively opposed an expansion of the pro-

gram of the Bureau of Handicapped Children into this field of medical care until standards of administration have been established. It is hoped that during the coming year further study of this problem can be made by the committee in cooperation with the Committee on Hearing Defects.

The lack of adequate provision for the education and medical supervision of spastics has prompted the Bureau of Handicapped Children to propose an extension of their "traveling clinic" program to care for this type of case. The proposed program has been reviewed by the Advisory Committee this past year, and it is anticipated that during the coming year a series of clinics, each of several days' duration, will be offered with a variety of consultants on hand to examine the children and provide the referring physician with pertinent data for continued care on a local level.

Recommendations

It is recommended that the future expansion of the rheumatic fever program in Wisconsin rests upon standards of operation which will be prepared by the Advisory Committee and submitted to the State Medical Society for approval. It is further recommended that the State Medical Society suggest to the Committee on Public Policy that it actively sponsor the passage of legislation which will provide adequate public funds, administered through the Bureau of Handicapped Children in cooperation with the Advisory Committee, for the establishment of convalescent homes for rheumatic fever patients, with qualifications for support based upon organization in keeping with the minimum standards approved by the State Medical Society.

It is further recommended that special attention be directed to the part the medical profession can take in the education and rehabilitation of spastics and those suffering from epilepsy.

Conscious of the need for better organization in the care of those stricken with poliomyelitis, it is recommended that the State Medical Society, in cooperation with the Wisconsin Hospital Association, the Conference of Catholic Hospitals, the State Board of Health, and the Bureau of Handicapped Children, present a program which will encourage the establishment of selected hospitals, other than the two in Madison and Milwauke for the care of those suffering from this disease. It is felt by the Advisory Committee that adequate medical studies of isolation have been carried out to indicate the practicality of regional care in a well equipped general hospital, and its advisability from the standpoint of benefits to the patient seem self-evident.

COMMITTEE ON COORDINATION OF MEDICAL SERVICES

C. O. Vingom, chairman; J. W. Prentice; S. E. Gavin; President, ex officio; Secretary, ex officio

In 1945, this committee, which represents the efforts of the profession to assure maximum public health utilization of the state hospital institutions in Madison, reported to this House its general conclusion that the proportion of private patients to the clinic and county patients was too large. It seemed apparent, however, that this was fully appreciated and steps were being taken to bring it back to allowable proportions.

It appears that the management of the institution favors the ideal of all patients being classified as "teaching cases" as against the 65 per cent admissions so classified at the time of the committee meeting.

There is every indication that the present policy of admitting the private patient only upon direct referral will be continued and within the limitation of thirty beds or less on the average during the year.

Various procedures leading to patient or physician misunderstanding have been discussed. Among these has been clarity of intent by referring physicians, i.e., diagnosis, or diagnosis and treatment,—reporting of findings, and delay in admissions.

As a result of these discussions, members of the committee are agreed that certain procedural aspects of the management of these institutions might well be stressed for the benefit of the profession as a whole. Consequently, it has been agreed that after committee consideration a statement on these various points will be published in *The Wisconsin Medical Journal.*

It seems apparent that continuance of meetings with the management of these institutions is highly advisable in the public health interest of Wisconsin. The institutions exist to further three major purposes: (1) medical research, (2) medical education, and (3) medical service. While none of these is subject to arbitrary limitation nor extension, proper effort must be continued to provide adequate clinical material for education and research without overburdening the facilities with an undue private patient load.

COMMITTEE ON GOITER

A. S. Jackson, chairman; E. W. Schacht; Millard Tufts; E. L. Sevringhaus; and C. N. Neupert

The work of the Committee on Goiter during the past year has been largely devoted to resuming the program which had to be dropped because of the war. Presidents of all county medical societies in the state have been requested to appoint Goiter Prevention Committees and to date, thirty-two committees have been appointed. The following county medical societies have not appointed committees: Columbia–Marquette–Adams, Crawford, Forest, Grant, Green Lake–Waushara, Iowa, Kenosha, La Crosse, Lafayette, Langlade, Lincoln, Marathon, Marinette–Florence, Oconto, Outagamie, Price–Taylor, Racine, Richland, Trempealeau–Jackson–Buffalo, Vernon, Walworth, and Waukesha.

Through the cooperation of the Board of Education, a complete school census for each county has been obtained. The county society Goiter Committees were requested:

1. To ascertain from their County Board Chairman what funds, if any, were appropriated for 1945 for the purchase of iodine tablets for distribution in the schools. Also if any funds have been appropriated for 1946.

2. To estimate what number of school children are receiving iodine tablets through the schools of the county.

3. To estimate the number of children who might be receiving treatment through their family physician.

4. To estimate the amount of iodized salt used.

Reports on this data have been received from a number of the committees. Communication has been received from Doctor Neupert, State Health Officer, favoring the use of iodized salt, but it is the belief of the chairman that if such a program were to be adopted for the entire state, a bill should be introduced in the legislature, making it compulsory for all salt used in Wisconsin to be iodized, such as the Michigan plan. The committee feels that before considering such a measure there should be further investigation on this subject.

If the present program of tablet distribution under the physicians of Wisconsin and through the schools is to be successful, it must have the support of not thirty-two of the county medical societies, but of all of them. An appeal is made to the presidents of such county societies to appoint Goiter Committees at once so that the program may be successfully carried on during the coming year.

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

Norbert Enzer, chairman; C. J. Newcomb; L. H. Lokvam; and L. R. Cole

The growing importance of public contacts of the medical profession through press and radio has prompted the Committee on Public Instruction to suggest intensified activities in these fields during the ensuing year. A review of the growth of the radio series presented to the public under the title, "The March of Medicine," and the increased acceptance of press releases from the office of the State Medical Society suggests that editors, radio station managers, and the general public are appreciative of the sincere efforts of organized medicine to promote a sound program of preventive medicine.

During this past year, special contacts have been made with the "Wisconsin Agriculturist and Farmer" magazine, and special promotional assistance has been given the school health radio program entitled "Fit For Service" over the state radio station, WHA, Madison. In addition, the State Medical Society has presented a health exhibit at the State Fair, and this past summer presented a series of exhibits at the more important county fairs.

Recommendations

In light of the increasing importance of sound public relations through press and radio, it is the earnest recommendation of the Committee on Health and Public Instruction that the Council provide sufficient allocation of funds so that a physician may assist to even greater degree in this field of activity.

COMMITTEE ON INDUSTRIAL HEALTH

D. E. Dorchester, chairman; M. J. Reuter; T. J. Howard; and L. W. Hipke

The Committee on Industrial Health has devoted its effort this past year to the establishment of better relationships between industrial nurses and plant physicians, and has tentatively formulated statements of principles which will serve as guideposts for the development of industrial health programs on a county level.

In joint conference with the Industrial Nurses Association, the Committee on Industrial Health has approved of proposed classifications and duties of industrial nurses with varying degrees of training, as well as concise statements of the relationship of industrial nurses to plant physicians and nonmedical personnel.

It is the hope of the Committee on Industrial Health that during the ensuing year, it will have the opportunity of working with representatives of management and labor on a state level to form the framework for basic principles to guide county programs as they are organized.

Recommendations: It is recommended that county medical societies in which industrialized areas exist effect a closer working relationship with management, labor, and industrial nurses, so that sound principles of industrial health will serve as the foundation for plant practices.

COMMITTEE ON MATERNAL AND CHILD WELFARE

W. C. Stewart, chairman; J. W. Harris; Robert F. Purtell; Amy Louise Hunter; and W. A. Wagner

Presenting its report before the 1945 session of the House of Delegates, the Committee on Maternal and Child Welfare emphasized the need to plan a strong state program to help combat the excuse of social planners in Washington to expand federal control over medical programs offered on the state level. In order to implement its recommendations, the Committee on Maternal and Child Welfare has directed its major attention this past year to methods which might be employed to improve the medical program in the state, especially as it relates to maternal and child welfare.

Meeting with the State Health Officer, the committee has reviewed existing facilities and presents a strong re-affirmation of its opinion that little progress can be made until the present public health services are intensified. In line with suggestions of

the State Board of Health this means a re-districting of Wisconsin so that more public health officers can be employed, and establishing a salary schedule for public health workers which will attract adequately trained personnel and provide them with sufficient professional inducement to encourage their continued service in the field of public health. It is the hope of the committee that the present plans of the State Board of Health can be achieved through legislative support, and that the now-depleted staff of district health officers can be adequately manned by the type of physicians who can carry out the program of the State Health Officer and the State Board of Health.

A second problem which has concerned the Committee on Maternal and Child Welfare is that of providing continuous and adequate postgraduate training for physicians. Alert to the need for the type of teaching program offered through the Continuation Center at the University of Minnesota the committee has initiated preliminary steps to have this type of training offered in Wisconsin. It is hoped that as the projected building program of the University of Wisconsin is translated into action, the State Medical Society and the State Board of Health will share in the planning as it would concern Wisconsin physicians.

The committee is pleased to report that both the fields of obstetrics and pediatric care were incorporated into the Postgraduate Teaching program this past June, and the interest in these two fields indicates a need for continuous teaching experiences of this type. In addition, the Annual Meeting program this year is repeating its Obstetric Manikin Demonstrations, which have proved such popular features of the Annual Meeting programs in 1943 and 1944.

The Committee on Maternal and Child Welfare has taken an active interest in the survey being conducted through the American Academy of Pediatrics, and when results of the survey have been completed and recommendations offered to the state the committee hopes to have the privilege of making further recommendations to the House of Delegates for methods which might be employed to offer such a strong and convincing health program that those who prey upon the alleged weaknesses of the medical profession cannot use Wisconsin as an excuse to build up a beaurocratic system of medical care, as embodied in the "Pepper Bill," which has died with this session of Congress but may well revive its efforts for centralized control in the next session.

COUNCIL ON MEDICAL SERVICE AND PUBLIC RELATIONS

Since the annual meeting of the House in 1945, the Council on Medical Service and Public Relations has met in four sessions and its subcommittees on other occasions. It has acted during this year as follows:

1. Advised the congressional representatives of Wisconsin, of the attitude of the profession of this state with reference to the Pepper Bill—S. 1318—as expressed by the House in its 1945 session.
2. Advised these same representatives of the positive maternal and child health program advocated for this state, and as approved by the 1945 session of the House.
3. Distributed to the physicians of Wisconsin a detailed bulletin on the provisions of the state law relating to the care of veterans.
4. In cooperation with the Wisconsin division of the American Academy of Pediatrics, is actively assisting in the child health survey in Wisconsin which is designed to secure accurate information upon which to base further recommendations for legislation in this field.
5. Reviewed the situation with reference to the Wagner–Murray–Dingell bill and approved the sending of representatives of the Society to Washington hearings.
6. Recommends the adoption by the House of Delegates of the 10 point program sponsored by the American Medical Association.
7. Advised in cooperation with the Committee on Health and Public Instruction the membership of current society activities in the field of radio activities, news releases and the like.

In addition to these matters, the Council has created several subcommittees to function in particular fields. By action of the House at its special session in 1946, the need for one of these no longer exists. A subcommittee to consider the development, cooperatively, of medical-legal courses in medical schools has been appointed and will function during the ensuing year. (A subcommittee on nursing problems has been appointed, but the complexity of the subject prevents any specific report at this time.)

Other matters pending, or upon which action has been taken follow:

1. The Council is engaged in studying the development of a Health Council in this state, composed of representatives of various of those organizations engaged in public health activities.
2. Because of the importance to medical organizations of the county secretaries, the Council has recommended that the annual conference be held at a time other than during the Annual Meeting.
3. The Council has reviewed the importance of various national conferences on health matters, and has approved Society representatives attending not only those on legislation, but on voluntary sickness insurance and cooperative health programs.

The Council recommends not only that the House of Delegates consider its efforts as outlined in this report, but in addition:

1. The Council believes that it, together with the Committee on Public Policy, and through accepted procedures of the Society, can actively function in the field of public relations, and as it gains experience, provide the Society with concrete proposals in that field.

2. The structure of the Council, however, might well be reviewed. As it stands today, five members are appointed annually by the president, and four are ex officio. The Council believes that its appointive members might well follow the pattern established for the Council on Scientific Work where the term of one member expires each year. A resolution to accomplish such a result will be offered to the House.

COMMITTEE ON MENTAL HYGIENE AND INSTITUTIONAL CARE

(Reporting also for the Advisory Committee to the Department of Public Welfare and the Special Committee of the President on the Incurably Ill)

H. H. Christofferson, chairman; B. J. Hughes; and A. W. Bryan

During the past year several significant meetings of this committee have been held at which were discussed several topics of vital concern to the medical profession, and which it is hoped will find expression in legislative action in the near future.

For several years the Committee on Mental Hygiene and Institutional Care has directed special attention to county institutions and the type of medical care offered patients on the county level. Medical surveys conducted by the committee have evidenced need for the adoption of minimum standards governing the medical care of patients housed in county asylums or homes. After conferences with superintendents of county institutions, the committee formulated a set of minimum standards which have been approved by the State Medical Society, and which have been adopted in about two-thirds of the county institutions in the state. The committee is encouraged with progress made to date in this field, but recognizes the fact that further progress cannot be made until the level of administrative and medical care is raised considerably above the minimum standards established.

Recognizing the value in coordinating its efforts with the Advisory Committee to the Department of Public Welfare, a joint meeting of the two committees was held, at which medical problems of institutional care on the county level were discussed. It was felt by both committees that specialized personnel should be provided the Department of Public Welfare so that standards of medical care in county institutions might be raised. The heavy load of work now carried by the medical director of the Department of Public Welfare indicated the impracticality of adding this task to his present duties, and so it has prompted the committee to recommend the following to the State Medical Society through its Committee on Public Policy:

(1) That a qualified physician (or a qualified physician and what other type of assistance is deemed advisable) be employed by the State Department of Public Welfare to inspect and supervise the medical care given in county institutions in Wisconsin. In providing such personnel, it is the recommendation of the committee that the State Department of Public Welfare exercise enlarged medical supervisory functions over county institutions, particularly in matters of survey, inspection, education, and the adoption and implementation of minimum medical standards.

(2) Recognizing that further improvement in institutional care on the county level is dependent upon highly qualified personnel, both in respect to medical care and administration, the committee has recommended that salaries for physicians, nurses, and superintendents of county institutions be increased so as to attract persons of ability and idealism for this type of work.

As the committee directed its attention to conditions in county asylums or homes, it became evident that many persons now housed in county institutions are in no way mental cases, and are in need of specialized medical treatment. The problem of the chronically ill and of seniles has prompted the committee to hold two separate meetings for the purpose of establishing standards governing any legislative action in this important field of medical care.

At the suggestion of President Minahan, a joint meeting of the Committee on Mental Hygiene and Institutional Care was held with the Committee on Incurably Ill, and representatives of the County Judges Association. Judges and physicians alike agreed that the commitment of seniles to county institutions primarily concerned with mental cases was a bad practice which should be stopped. It was agreed that special institutions are needed for the aged ill and seniles. Members of the committee feel unanimously that future development of a statewide program to care for such persons should not consist of two or three state institutions, but that such care should be provided on a county level in populous areas, and that in the North, facilities should be provided to care for three or four counties at the most in a single institution. The importance of this problem and the need to develop a program based upon sound medical practice prompted the committee to appoint a special sub-committee, representative of the medical profession and the county judges, to meet with the special legislative committee concerned with the same question. It is hoped that during the ensuing year, preliminary legislative steps can be taken so that a well-conceived and adequately financed program can be initiated.

In addition, the committee personnel has consulted with the legislative interim committee concerned with revision of Sections 51 and 52 of the Wisconsin statutes pertaining to institutional care and commitment procedures.

Increased public awareness of the responsibilities of society to provide special care for the aged and

the chronically ill prompts the committee to recommend that during the ensuing year special efforts be made to coordinate the various committees within the State Medical Society concerned with these problems, so that the planning of state-wide programs can be conducted along lines of sound medical practice.

COMMITTEE ON RURAL HEALTH AND ACCIDENT PREVENTION

H. J. Gramling, chairman; R. L. MacCornack; J. J. Minahan

The work of the Committee on Rural Health and Accident Prevention this past year has been restricted to initial evaluation of farm accidents as they actually occur in a typical Wisconsin community, and the establishment of a closer working relationship between the State Medical Society and the newly organized health program of the 4–H Clubs in Wisconsin.

The committee has had the pleasure of meeting with 4–H Club leaders, and has approved the revision of the health program advocated for use in Wisconsin, which will encourage group health projects and establish awards of merit upon club achievements rather than upon superior health standards of a single boy and a single girl in the county and then in the state. The Committee on Rural Health and Accident Prevention urges cooperation of all county societies in this worthwhile project.

Recommendations: It is the recommendation of the Committee on Rural Health and Accident Prevention that the committee's inquiry into the nature of farm accidents, based upon a sample survey, be continued, and that during the ensuing year special attention be directed to the medical aspects of the undulant fever problem and its relationship to the dairy industry. It is suggested that conferences be held with representatives of the State Department of Agriculture, the College of Agriculture, and the State Board of Health to see what medical aspects of the program should come before the attention of the State Medical Society.

COUNCIL ON SCIENTIFIC WORK

C. D. Neidhold, chairman; F. D. Murphy; E. R. Schmidt; C. F. Midelfort; J. M. Freeman; K. H. Doege; W. S. Middleton; and E. J. Carey

By precedent the duties and the responsibilities of the Council on Scientific Work are quite well prescribed, and the activities of the Council this past year have been largely devoted to its special fields.

In keeping with custom, the Council, through the assistance of Dr. E. R. Schmidt and various section chairmen, has provided the scientific program for the Annual Meeting. In cooperation with Dr. H. M. Coon, Madison, and Dr. W. S. Middleton, Madison, the Council has been pleased to re-instate the Postgraduate Teaching Clinics for the benefit of the membership of the State Medical Society. A third project, which the Council has fostered with marked success in Rock County, is the stimulation of localized medical research projects. It is hoped that this activity will be greatly increased during the ensuing year.

Under the able direction of Dr. Karl H. Doege, Marshfield, the Council has had the pleasure of presenting many scientific articles of merit to the membership through the columns of *The Wisconsin Medical Journal.* In the opinion of the Council, the scientific section of our official organ is outstanding in the field of medical periodicals. This year, to assist Doctor Doege in the evaluation and selection of scientific articles, a special advisory committee has been appointed, the personnel of which is composed of Drs. H. Kent Tenney, Madison; M. L. Jones, Wausau; E. W. Mason, Milwaukee; J. L. Garvey, Milwaukee; and G. W. Carlson, Appleton.

Recommendations

The Council on Scientific Work, as a service committee of the State Medical Society, does not recommend any new projects for the coming year, but continuation of its present program. It is the belief of the Council that members of the State Medical Society are highly professionally minded, and their enthusiastic acceptance of scientific programs presented through the agency of the Annual Meeting and the Postgraduate Teaching Clinics has given members of the Council on Scientific Work the satisfaction of knowing that their efforts are in line with the purposes and wishes of the State Society.

COMMITTEE ON TUBERCULOSIS AND CHEST DISEASES

L. O. Simenstad, chairman; A. V. Cadden; and A. A. Pleyte

Several important projects have been undertaken by the Committee on Tuberculosis and Chest Diseases this past year, and while the end results of some are still forthcoming, it is the feeling of the committee that progress in this field has been made during the past twelve months, since the committee has last had the pleasure of reporting its work to the House of Delegates.

During the past year the committee has had the pleasure of meeting with representatives of the Wisconsin Association of Nurses to assist them in providing standards governing the physical examination of nurses in training, and nurses in service, which have become requirements in all schools of nursing in Wisconsin. The culmination of this project will have beneficial results for the entire state, as surveys conducted among nurses in training have indicated a dire need for periodic and careful chest examinations, with x-rays, of those being trained for the profession of nursing in Wisconsin hospitals.

Another subject of inquiry directed to the committee is that of establishing a program of routine chest x-rays of all hospital admissions. While the

program has many problems yet unsolved the committee feels it is of sufficient medical importance to indicate continued study and recommendations at a later date. It is hoped that during the current year more progress can be made in this field, so that certain basic principles and established standards of practice will be followed as more hospitals concern themselves with this health problem.

A third specific project stimulated by the committee is that of tuberculosis among teachers and the responsibility of school boards to assure adequate protection to students through the use of chest examinations. The basis of this inquiry is summarized by an article published in the May issue of *The Wisconsin Medical Journal* (pages 497–500). After consultation with representatives of the Wisconsin Schoolboards Association, the Wisconsin Education Association, and the State Superintendent of Schools, it was agreed that there is need for more public consciousness of the problem involved, and it has been suggested that efforts be made during the next legislative session to provide the means through which schoolboards concerned with this medical problem might legally expend public funds for the financing of a teacher examination program restricted to establishment of proof that the teacher is free of a communicable disease which might be transmitted to pupils and fellow teachers.

Recommendations

It is the recommendation of the Committee on Tuberculosis and Chest Diseases that:

(1) Steps be taken through the Wisconsin Hospital Association and The Conference of Catholic Hospitals to establish minimum standards governing the periodic examination of student nurses and nurses in service to detect the early contact of tuberculosis due to employment.

(2) Further study be directed to the routine examination by x-ray of all hospital admissions, so that specific recommendations can be made to the State Medical Society, in the interest of better public health and the protection of hospital personnel and patients alike.

(3) During the next legislative session, the State Medical Society, through its Committee on Public Policy in cooperation with the State Board of Health and other interested health agencies, consider fostering permissive legislation which will provide opportunity to schoolboards through local health agencies to expend public funds for the chest examination of teachers and other school personnel, where in the opinion of the state health officer such an examination would be of concern to the public health. It is further recommended that in cooperation with the Committee on Tuberculosis and Chest Diseases the state health officer establish minimum standards for such examinations and determine recommended procedures to follow.

Recent Wisconsin Licentiates

At a meeting held in Milwaukee on June 25, 26, and 27, the Wisconsin State Board of Medical Examiners licensed the following physicians in the practice of medicine after they had successfully passed an examination.

Name	*School of Graduation*	*Year*	*Address*
Akwa, Carl Malcolm	Wisconsin	1945	2634 N. Maryland, Milwaukee
Bardeen, Ann	Wisconsin	1945	23 Mendota Ct., Madison 5
Bergen, Paul M.	Marquette	1945	618 Ash Street, Norway, Michigan
Bauch, Norbert Geo.	Marquette	1945	2259 62nd Street, Wauwatosa
Bode, Michael Jos.	Marquette	1945	6616 3rd Avenue, Kenosha
Bradley, Robert James	Wisconsin	1945	2715 N. Summit Avenue, Milwaukee 11
Burdick, Harvey Laurence	Wisconsin	1943	Milton
Clark, Gerald Robert	Oregon	1942	Wisconsin General Hospital, Madison
Clasen, Walter E.	Marquette	1945	3172 N. 50th Street, Milwaukee
Coenen, Mary Helen	Wisconsin	1944	2128 Keyes Avenue, Madison
Egan, Gregory J., Jr.	Northwestern	1945	134 S. 14th Street, La Crosse
Erickson, John Robert	Wisconsin	1945	1312 N. 15th Street, Sheboygan
Evans, Frederick L.	Marquette	1945	Westboro
Everest, Paul Daley	Wisconsin	1945	208 2nd Street, Merrill
Farrell, Robert X.	Marquette	1945	619 E. Madis, Springfield, Ohio
Flynn, Richard T.	Marquette	1945	1338 Harrison Avenue, Milwaukee
Ford, John Laurence	Marquette	1945	403 W. 6th Street, Appleton
Fountaine, Thomas J.	Wisconsin	1945	Elkhorn
Fox, Gerald Earl	Marquette	1944	St. Lukes Hospital, Milwaukee
Gordon, Norvan Floyd	Wisconsin	1943	426 10th Street, Rochester, Minnesota
Halberg, Avery Carl	Wisconsin	1945	1719 Johnson Street, La Crosse
Hawley, Robert L.	Marquette	1945	627 Joaquin, Reno, Nevada
Heggestad, Gilman Eldon	Wisconsin	1945	1255 Lancaster Avenue, Roscmont, Pa.
Henke, Frederick Wm.	Wisconsin	1945	Neshkoro
Hennen, Richard John	Wisconsin	1943	Pers. Ctr. Ft. McPherson
Hogan, Larry Howlett	Wisconsin	1944	2923 N. 29th Street, Milwaukee
Jackson, Robert Carl	Wisconsin	1945	1401 N. 21st Street, Superior

Name	School of Graduation	Year	Address
Jones, Warren Leslie	Temple	1945	7440 S. Eggle, Chicago, Illinois
Kumasaka, George	Northwestern	1946	Milwaukee County General Hospital, Milwaukee 13
Lagonegro, John Harry	Marquette	1944	6210 W. Lloyd Street, Milwaukee
LePoidevin, Jean S. (F.)	Wisconsin	1945	North Bay, Racine
Maas, Donald Wm.	Northwestern	1943	4043 N. Downer Avenue, Milwaukee
Markson, John Wright	Marquette	1943	Officers Lnge., U.S.N.H., Great Lake, Ill.
Mazzitello, Wm. Frank	Marquette	1945	2089 Sargent Avenue, St. Paul, Minnesota
McCullough, John Chas.	Wisconsin	1945	North Fond du Lac
Meyer, Bertram Jack	Wisconsin	1945	4421 N. Cramer Street, Milwaukee
Miner, Delbert Lamar	Wisconsin	1944	1521 E. Kane Place, Milwaukee 2
Moon, John Wm.	Wisconsin	1945	101 4th Street, Baraboo
Nielsen, Wm. Arthur	Wisconsin	1945	534 S. 8th Street, West Bend
Nitshe, Geo. A., Jr.	Hahnemann	1938	Wisconsin General Hospital, Madison
O'Connell, James	Marquette	1945	3702 W. Vliet, Milwaukee
Osborne, Rollin Robert	Wisconsin	1944	Hartford
Peters, Henry Augustus	Wisconsin	1945	224 Lake Road, Oconomowoc
Pfeifer, Wm. Murray	Marquette	1945	4429 N. Prospect, Milwaukee 11
Randolph, William C.	Wisconsin	1944	710 North Street, Madison
Reichardt, Frederic W.	Wisconsin	1943	103 Strauss Street, Indianhead, Md.
Retter, Richard Henry	Wisconsin	1943	Neceda
Rowe, Geo. Giles	Wisconsin	1945	Route 3, Dodgeville
Schlaeger, Ralph	Wisconsin	1945	3325 W. Noble, Milwaukee
Scott, Wm. Nugent	Marquette	1945	4501 S. Pine, Milwaukee
Silber, Earl Norman	Wisconsin	1945	3019 N. 45th Street, Milwaukee
Sorensen, Harold Emil	Wisconsin	1945	713 Madison Court, Racine
Stover, Wm. Harrison	Oklahoma	1945	5000 Chambers, Milwaukee
Talbot, Allan Eugene	Wisconsin	1945	317 E. North Street, Appleton
Theisen, James Kenneth	Wisconsin	1944	Fond du Lac
Troubalos, Stephen	Marquette	1943	Carlisle Barracks, Pa.
Vig, Edward Nels	Wisconsin	1945	110 W. South Street, Viroqua
Welsh, Edwin Charles	Illinois	1943	300 E. Howard Street, Portage
Wilson, Wm. Crosbie	Northwestern	1946	604 Hill Avenue, Glen Ellyn, Illinois
Witte, Keith Burton	Wisconsin	1945	29 N. 2nd Street, Madison
Wood, Hobart Rowe	Marquette	1944	822 Wisconsin Avenue, Racine

The following physicians were granted licenses through reciprocity in Milwaukee on June 26.

Name	School of Graduation	Year	Address
Balkan, John Bruce	Washington	1943	Chetek
Bennett, Abner P.	Syracuse	1940	15 West Dayton, Madison
David, John J.	Iowa	1943	Durand
Falk, Victor S.	Wisconsin	1939	Route 4, Box 22, Edgerton
Gutman, Emil	Illinois	1939	319 Third Street, Wausau
Haedike, Wm. David	Illinois	1942	4546 N. Damen Avenue, Chicago, Illinois
Hansen, Robert M.	Baylor	1939	Wisconsin General Hospital, Madison
Hoffman, Geo. T.	Marquette	1944	1585 S. 76th Street, West Allis
Hulse, Roy A.	Louisville	1939	135 Wells Street, Peekskill, New York
Leach, John Edward	Wisconsin	1936	800 Indiana Avenue, Mendota, Illinois
Lewinnek, Walter	Northwestern	1937	Oregon, Wis.
Lewis, Russell F., Jr.	Wisconsin	1941	202 S. East Avenue, Waukesha
Lococo, Thomas N.	Cincinnati	1944	608 E. Lyon Street, Milwaukee
Louisell, Charles	Wisconsin	1945	508 W. Milwaukee, Janesville
Lynch, Joseph S.	Minnesota	1935	302 E. 9th Street, Chester, Pa.
Macaulay, Warren L.	Minnesota	1943	Marshfield
Miller, Walton Hoy	Cincinnati	1941	605 Commonwealth Avenue, Boston, Mass.
Moberley, Paul B.	Illinois	1941	3831 N. Freemont St., Chicago 13, Illinois
Moore, Wm. James	Chicago	1938	1214 Spring Street, Madison 5
Pelton, Russell S.	Louisville	1942	Waupaca
Radke, Lucille M. (F)	Woman's Medical College of Virginia	1940	Chetek
Ramlow, Robert W.	Wisconsin	1943	2610 Coss Street, La Crosse
Rosenbaum, Francis	Michigan	1936	1313 E. Ann Street, Ann Harbor, Mich.
Schiffler, Robert	Marquette	1942	3508 W. Kilbourn Avenue, Milwaukee
Schmitt, Robert Wm.	Iowa	1935	Route 2, Box 109, Montgomery, Alabama
Schwab, Robert L.	Kansas	1942	412 N. Bartlett, Shawano
Steube, Ronald W.	Buffalo	1931	62 Congress Street, St. Paul, Minn.
Taylor, Charles W.	Virginia	1933	Kings Park Hospital, King Park, N. Y.
Toth, Szigmund J.	Louisiana	1943	Galesville
Verberkmoes, John G.	Oregon	1942	917 Lake Court, Madison 5
Weber, Joseph	Rush	1936	2445 N. 50th Street, Milwaukee
Werbel, Harold J.	Wisconsin	1939	7759 Yates Avenue, Chicago, Illinois

Looking at Sickness Insurance Abroad

By J. G. CROWNHART

Just prior to his death in Cleveland in 1941, J. G. Crownhart, Secretary of the State Medical Society of Wisconsin, addressed the Health and Accident Underwriters Conference in Chicago on "Looking at Sickness Insurance Abroad." With the current hearings and discussion on the Wagner-Murray-Dingell legislation and the whole subject of compulsory sickness insurance, it seems again timely to present Mr. Crownhart's paper in The Wisconsin Medical Journal. For the convenience of the reader, the whole paper was published in the July, 1941, issue of the Journal. It will be reprinted in installments in current issues of the Journal of 1946, beginning with the June issue and continuing through the October issue.

PART IV

(Continued from the August Journal)

Rules For the Physician

AND then there are rules for the physician too. For despite the fact that the system has used the physician as a reinsurer, what the physician prescribes and what he tells the patient to do cost the system money, and this expenditure can be controlled only by controlling the physician. Not only does such control exist, but it is tightened from time to time as the financial exigencies indicate, or in fact, may require.

Every system has rules and regulations for the physician,—frequently published in the form of a little pamphlet. Here are the treatments he may use; here are the drugs he may prescribe; here are the amounts of drugs he may prescribe; and here are the exact forms in which he may prescribe them. Here is the "book" within which he must stay. The average prescription cost in England, for instance, is from 16 to 18 cents, including the container. Even pennies count, and so the administration that has paid the physician on a per-patient per-year basis cares not how many times the patient returns to the physician in order to secure prescriptions as they are needed, but the system *is* concerned if a physician should prescribe amounts that conceivably might be more than required or drugs of an expense that the premium failed to anticipate.

I visited in the city of Lincoln (England). It so happened that I was in a certain physician's office, and while I sat there a call came in from the administrator's office. He had been in the administrator's office previously and they had been going over one of these cases. I turned to the physician, and now I am explaining what was inherent to that system. That doctor said, "I had a patient who was not doing well. I picked up my British Medical Journal and read of some work being done in the States in cases similar to mine. I had used prescriptions,—three, four, or five of them,—without my patient making any recovery. So I tried this one,—now my patient is well." But the average cost of a prescription in England, including the container when the physician "stays within the book," is from 16 to 18 cents. This particular prescription that this doctor used cost about $2.25, in our money. In other words, that doctor "went outside the book." And he was called upon to explain to the administrator, regional medical officer, or the panel committee largely consisting of laymen who obviously would know nothing about such things, why, for a patient they had not seen, a particular treatment was used. This physician had "gone outside the book," and he said, "It does take a bit of doing, and if I can't explain it satisfactorily, it is deducted from my next check."

Now that is entirely foreign to our concept of care here. We do whatever is necessary whenever it is required. And the physician says, "We will take care of the cost later."

"Sickness Licensing System"

And now do you see how the physician, as time goes on, finds his office more and more filled by patients who are there to secure another prescription and another certification for continued cash benefits. When I was in England, there had just been issued after a long period of study an exhaustive report on the British health services by one of the leading economic institutes of the land. In commenting on this exact point, this report declared, "Excessive numbers of panel patients and excessive demands for certificates and returns of all kinds quickly reduce the general practitioner to an agent for making out prescriptions (too often for mere palliatives), and for operating something more like a sickness licensing and registration system than a health service." Is it any wonder that Rubinow pointed to the fact that the term "health insurance" was a politician's subtle way of selling a wrapped package?

The whole thought of early service as a means of health security is inevitably lost. The theory and social service concept of the law is replaced by the cold, hard, actuarial experience, the operation of which always comes as such a shock to one who looks upon insurance as a source of a gift rather than as a means to a service, the actual extent of which depends solely upon coverage and actuarial computations.

"Oh," says the proponent of "health insurance," if we but had this plan in operation the physician who is waiting for patients, and the patients who have need for the physician, would be brought together." Now, may I assure you first of all that where choice of physician exists, the busy physician becomes the busier physician. The physician less busy and because of this having lower fees, under such a system has even less to do for with the removal of the fee differential, patients go to the physicians of the greatest prominence within the realm of choice.

And next, proponents of compulsory sickness insurance say to you that with removal of the so-called economic barrier between the patient and health, he can at last secure adequate and timely service. Unfortunately, this patient finds himself facing the barrier of rules and regulations; the barrier of a physician too busy "licensing his patients" as the English put it, to have time to give the adequate care that the social service concept visualized. The patient finds the physician himself governed by rules and regulations. The patient finds a physician, who, if he goes outside the costs of treatment laid down by the rules, will face a paycheck deduction of his own come the next quarterly pay day. And so the physician tends more and more to stay inside his book of instructions; to accept the legislation for what it is, recognizing eventually the futility of attempting to repeal it; recognizing that if he is critical of the system, he will not long remain a part of it; recognizing, as so many physicians put it abroad, that "we must do the best we can and get on with it." An assumed barrier has been exchanged for very realistic ones.

(To be continued)

Physicians in Service

For many months material in this section was carried under the title of "The Nation at War." With physicians still entering service, with many returning to reestablish themselves in civilian practice, and with many planning to continue in service for an indefinite time, it is the decision of the *Journal* to continue the section under a more timely title.

Returning Veterans

After forty-six months in the Army, Captain Herbert J. Apfelberg received his discharge and has returned to Milwaukee to open his office for the practice of neurology and psychiatry.

Entering the service in September of 1942, Captain Apfelberg was assigned as assistant chief of neuropsychiatry at Billings General Hospital, Fort Benjamin Harrison, then served as assistant chief of the psychiatry and sociology section of the Midwestern Branch, U. S. Disciplinary Barracks at Fort Benjamin Harrison, and finally, in July, 1945, was transferred to Milwaukee to become chief of the psychiatry and sociology section of the Northern Branch, U. S. Disciplinary Barracks.

Prior to his entrance into the Army, Captain Apfelberg was resident in neuropsychiatry at the Milwaukee County Hospital for Mental Diseases.

Lieutenant (j. g.) Norman O. Becker, Fond du Lac, was separated from the United States Naval Reserve July 2 in Los Angeles, and has resumed resident training in surgery at City Hospital, Cleveland. His terminal leave expired August 22.

Edgerton practitioner, Commander George F. Burpee, who entered the Navy July 19, 1943, received his discharge April 1, and has reopened his office. Commander Burpee's first military assignment was at the training station at Farragut, Idaho. After almost a year at that station, he was transferred to the Universiy of Minnesota Navy Unit where he served as senior medical officer until October of 1944. Commander Burpee then reported for duty in the Pacific on the USS Grafton (A.P.A. 109) as senior medical officer. Upon returning to this country in January, 1946, the doctor was discharged at Great Lakes, Illinois.

Commander Burpee wears the Asiatic-Pacific and American Theater ribbons with a star award for service on Okinawa.

After rendering service in the Army since January 27, 1944, Captain A. T. Buscaglia of Milwaukee received his discharge in November of 1945. He has since resumed his practice. While in the Army, Captain Buscaglia served at Carlisle Barracks, Pennsylvania; Fort Jackson, South Carolina; with the 141st General Hospital in England; and

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with the 108th Evacuation Hospital in France, Belgium, Holland, Luxembourg, and Germany. He is entitled to wear the European Theater of Operations ribbon with battle stars for Northern France, Central Europe, and Germany.

Lieutenant Commander Robert L. Dana of Fond du Lac, who was discharged from the Navy April 15, has moved to Kalamazoo, Michigan, and started a practice in that city.

Entering the Navy in October, 1942, the doctor was sent to Great Lakes, Illinois, for two months. His record shows he then served with the following Marine and Naval units: 1st Marine Amphibian Corps, New Caledonia, Vella Lavella, and Guadalcanal; 4th Marine Regiment, Guadalcanal, and Emirau; 1st Provisional Marine Brigade, Guam; 6th Marine Division, Guadalcanal; Navy V–12 Unit, Western Michigan College, Kalamazoo, Michigan; and Naval Air Station, Minneapolis, Minnesota.

Commander Dana wears the American, and Asiatic-Pacific Theater ribbons with three battle stars. He also has the Navy Unit Commendation for service on Guam.

Major Douglas A. Gutheil, who was junior resident at the Muirdale Sanatorium, Milwaukee, at the time he entered the Army, October, 1942, received his discharge January 4, and has returned to the sanatorium as full time physician.

Major Gutheil was stationed at the Army Air Forces Officer Training School in Miami, Florida, for several months and then was sent to March Field Station Hospital at Riverside, California. In March of 1943 he transferred to the Randolph Field School of Aviation Medicine, San Antonio, Texas. Major Gutheil spent twenty-one months overseas, serving with the 364th Fighter Group of the 8th Air Force, beginning in June, 1943.

He wears the European-African-Middle Eastern and American Theater ribbons with six battle participation stars: Air Offensive Europe, Normandy, Northern France, Rhineland, Ardennes, and Central Europe.

Captain Kenneth L. Haman, who served three years with the Army Air Forces as flight surgeon, has recently joined his brother-in-law, **Dr. H. C. Schmallenberg**, in practice in New London. Captain Haman's terminal leave expired September 1.

The doctor entered military service from internship at County Hospital, Milwaukee, and was stationed at Amarillo, Texas; Carlisle Barracks, Pennsylvania; San Antonio, Texas, where he attended the Randolph Field School of Aviation Medicine; and Orlando, Florida. He then returned to Amarillo, was assigned to Great Falls, Montana, and later to Fairbanks, Alaska, where he remained four months. He then received an appointment as post surgeon at the base hospital of Stockton Field, California.

After three and one-half years as a physician in the Navy, **Lieutenant Commander Walter C. Kleinpell** of Kenosha received a discharge February 12. The doctor served at the Naval Dispensary at Farragut, Idaho, until he joined Mobile Hospital Unit #2 for duty in the Southwest Pacific. In July, 1944, he transferred to Base 10 at Sydney, Australia, remaining there for six months. Commander Kleinpell's last station was the Great Lakes, Illinois, Naval Hospital. He is a wearer of the Asiatic-Pacific Theater ribbon with two bronze stars.

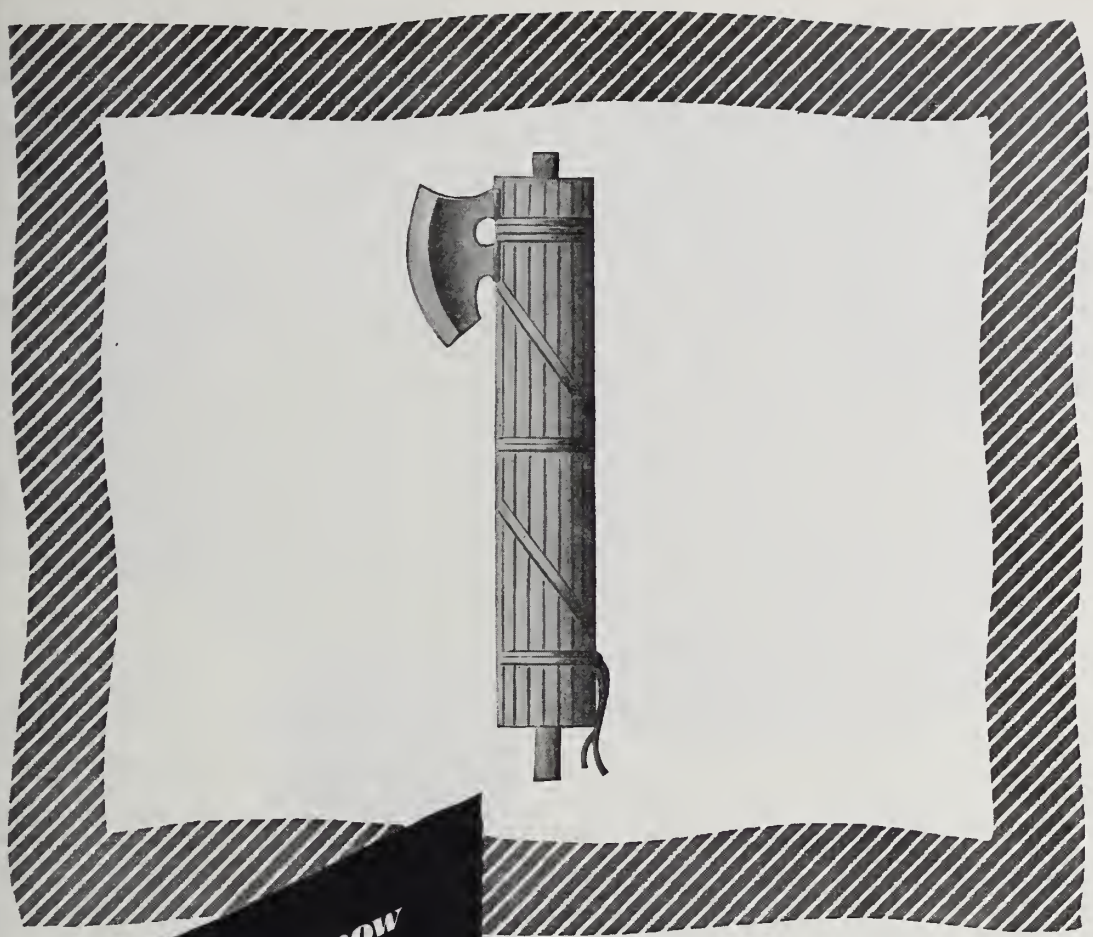
J. F. KLEPFER

Lieutenant Colonel Jefferson F. Klepfer, superintendent of Central State Hospital at Waupun before he entered the service in August, 1943, was discharged July 1. Upon joining the Army, Colonel Klepfer was sent to Carlisle Barracks, Pennsylvania, to attend the Medical Field Service School for a month. He was asigned duty at O'Reilly General Hospital, Springfield, Missouri, for two months—until transferred to the 28th General Hospital, Swannanoa, North Carolina.

Going overseas in December, 1943, the doctor served in the European Theater with the 28th General Hospital, the 7th Convalescent Hospital, and the Cales Staging Battalion until March, 1946. Colonel Klepfer is entitled to wear the European Theater of Operations ribbon with three battle stars, and the Commendation ribbon.

Captain Philip W. Limberg of Plymouth, received a discharge from the Army recently after having rendered military service since August of 1943. Upon graduation from the Medical Field Service School at Carlisle Barracks, Pennsylvania, Captain Limberg reported to the 30th Infantry ("Old Hickory") Division on maneuvers in Tennessee. In November, the doctor moved with the division to Camp Atterbury, Indiana, and in February of 1944, sailed for England. On D-Day plus six, Captain Limberg, as a medical officer in a collecting company, crossed the English Channel. The doctor remained with the 30th Division, serving in almost every type of medical set up, for eleven months of combat from the beaches of Normandy to the Elb River. Before returning to the United States in October, 1945, he spent four months as assistant camp surgeon of Camp Oklahoma City, near Rheims, France.

Captain Limberg wears the European Theater of Operations ribbon with stars for the campaigns of Normandy, Northern France, Rhineland, Ardennes, and Central Germany. He was awarded the Presidential Unit Citation ribbon, the Bronze Star, and the Combat Medics Badge.



Do you know what these symbols stand for?

The emblem above, appearing on the reverse of the U. S. Liberty dime, is known as the "fasces." It depicts a bundle of staves enclosing an ax and was the ancient Roman symbol of authority. On our dime it stands for the "unity wherein lies our strength."

The familiar sign, to the left, is the Rexall symbol of reliable pharmaceutical service wherein lies safety. It appears on selected neighborhood drug stores throughout the country, and stands for laboratory-tested Rexall drugs and selected pharmacal ability in compounding them. Your prescriptions filled at these Rexall Drug Stores combine both ingredients and skill unsurpassed for *quality control.*

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PHARMACEUTICAL CHEMISTS FOR MORE THAN 43 YEARS

S. W. HOLLENBECK

Completing over five years of service with the Army, **Lieutenant Colonel Stanley W. Hollenbeck** was discharged January 30, and resumed his practice in Milwaukee.

Colonel Hollenbeck's first post was Camp Livingston, Louisiana, where he served with the 32d Infantry Division. In November, 1942, he went overseas to render service with the 14th Portable Surgical Hospital at Buna, New Guinea, until March 1, 1943, and with the 32d Infantry Division in Australia and New Guinea until October, 1944. He wears the Asiatic-Pacific Theater ribbon, and was awarded the Silver Star Medal and the Distinguished Unit Citation.

Port Washington practitioner, **Lieutenant Commander Charles P. Kauth**, who entered military service in December, 1943, was discharged May 17, and has reopened his office. Commander Kauth's first post in the Navy was the U. S. Naval Training Station at Farragut, Idaho. Later he served with G-7, Group #2, at San Bruno and Shoemaker, California; the Naval Advanced Base, Unit #3, Navy #936; on board the USS Taylor (DD 468), and at the U. S. Naval Hospital at Mare Island, California. Commander Kauth wears the Philippine Liberation ribbon with one bronze star, the Asiatic-Pacific Theater ribbon with three bronze stars, and the American Theater ribbon.

Former resident at Milwaukee Children's Hospital, **Captain Henry Veit** was released from active duty with the Army July 14 and has become resident in psychiatry at the Psychopathic Hospital, Denver, Colorado. After entering the Army in January, 1944, Captain Veit served at the following stations: Carlisle Barracks, Pennsylvania; England General Hospital, Atlantic City, New Jersey; with the Military Neuropsychiatry Class at Columbia University, New York City; Station Hospital, Camp Claiborne, Louisiana; and Camp Chaffee, Arkansas.

Major Raymond F. Wagner has resumed his practice in Oshkosh following receipt of a discharge from the Army May 14. Beginning his military service in October of 1943, the doctor was sent to the Medical Field Service School at Carlisle, Pennsylvania, for a month. He then served four months at Cushing General Hospital, Framingham, Massachusetts. Major Wagner's last duty was as surgeon at the Prisoner of War Camp at Fort Devens, Massachusetts. He wears the American Theater and Army Commendation ribbons, and was awarded the Meritorious Unit Service Plaque and citation.

Lieutenant Robert F. Schilling, formerly of Adell, recently received a discharge from the Medical Corps of the Naval Reserve, and has accepted a residency at Wisconsin General Hospital, Madison. At one time during the war Lieutenant Schilling served with Headquarters, 94th Marine Division in the Pacific Theater.

Captain Harvey R. Sharpe, Jr., Fond du Lac, after thirty months of service, was recently discharged. Entering the Army in February, 1944, the doctor served in a hospital in this country until June of that year, when he was sent overseas and stationed at the 114th General Hospital, Worchestershire, England, to give orthopedic service for a year. Captain Sharpe was enroute to Manila when the Japanese surrendered. Instead of going on to the Pacific Theater, he returned to this country and reported for duty at the Regional Hospital, Camp Crowder, Missouri, and later at the station hospital at Fort Riley, Kansas, where he was attending physician at the out-going patients clinic.

C. W. STOOPS, JR.

Lieutenant Charles W. Stoops, Platteville, who entered the Navy July 10, 1943, received a discharge June 13, after serving in this country and overseas. The doctor is now a resident in dermatology at Ann Arbor, Michigan. While in military service, Lieutenant Stoops was stationed at the U. S. Naval Hospital, Norman, Oklahoma, and with the 7th Marines, 1st Marine Division, FMF. He wears the Pacific Theater ribbon with four stars.

A veteran of three years service with the Army Air Forces, **Major Jack D. Schroeder** of Janesville, was released from active duty June 25, and has become associated with the Munn-Koch Clinic in Janesville. Major Schroeder, who entered military service in July, 1943, was on the medical services staff of the Air Force's Regional Hospital at Greensboro, North Carolina.

Milwaukee physician, **Lieutenant (j. g.) James P. Semmens**, was released from active duty with the Naval Reserve June 29, and has formed an association with **Dr. K. A. Swartz** in medical practice and in operation of the Clark and Swartz hospital. Lieutenant Semmens entered the Navy in 1942. For the fifteen and one-half months prior to his release, the doctor was on duty in the Pacific. He was medical officer aboard a heavy destroyer for some

First breath, first bath, first bottle

In a life filled with "firsts", baby has no time to cope with such gastro-intestinal problems as carbohydrate fermentation and attendant distention and diarrhea—particularly during his first few weeks.

'Dexin' has proven an excellent "first carbohydrate" because 1) its high dextrin content is not fermentable by the organisms usually present in the intestinal tract, and 2) because it promotes the formation of soft, flocculent, easily digested curds.

Simply prepared in hot or cold milk, 'Dexin' brand High Dextrin Carbohydrate is easily adapted to increasing formula needs from month to month, and later, being palatable but not too sweet, is a welcome supplement to other bland foods. 'Dexin' *does* make a difference.

'Dexin' BRAND HIGH DEXTRIN CARBOHYDRATE

Composition—Dextrins 75% • Maltose 24% • Mineral Ash 0.25% • Moisture 0.75% • Available carbohydrate 99% • 115 calories per ounce • 6 level packed tablespoonfuls equal 1 ounce • Containers of twelve ounces and three pounds • Accepted by the Council on Foods and Nutrition, American Medical Association.

Literature on request 'Dexin' Reg. Trademark

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Prescribe Journal-advertised products and you prescribe the best.

months, and for eight months was senior medical officer at the Naval Base, Ponape, Caroline Islands.

SAMUEL HARPER

Dr. Samuel B. Harper recently received a discharge from the Army after three years of service, twenty-five months of which were spent in the Pacific area. The doctor, a son of **Dr. C. A. Harper**, former state health officer and now a consultant with the State Board of Health, practiced in Minnesota before the war, but now has opened an office in Madison to specialize in surgery and surgical diagnosis.

While in the Army Medical Corps, Doctor Harper was assigned duty with the 233d Station Hospital in Australia and New Guinea, and with a surgical team in the Philippines.

Lieutenant Colonel George C. Owen of Oshkosh was discharged from the Army Medical Corps April 16, and has located in Washington, D. C. Colonel Owen's three and one-half years of military service, started in November of 1942, were spent at Fitzsimons General Hospital, Denver, Colorado, and Bruns General Hospital at Santa Fe, New Mexico.

Dr. Bryce Ozanne of Neenah, who received a discharge from the Army Medical Corps early this spring, recently moved to Salt Lake City, Utah, to establish a practice with two other doctors, specializing in the field of anesthesiology.

Among the stations where Doctor Ozanne served, after entering the armed forces May 5, 1944, were: Carlisle Barracks, Pennsylvania; Tilton General Hospital, Fort Dix, New Jersey; and overseas, with the 64th Field Hospital.

Milwaukee physician, **Major Saul L. Parks**, who entered the Army in August, 1943, was discharged July 22. The doctor served with the 184th Engineering (C) Battalion at Camp Maxey, Texas, for almost a year before reporting to the Clearing Station, 94th Infantry Division, Camp McCain, Mississippi. Major Parks saw action with the 94th Division in France, Belgium, Germany, and Czechoslovakia, and then transferred to the 508th Parachute Infantry Regiment, serving in Germany until he returned to this country in April, 1946.

Major Parks is entitled to wear the American Theater ribbon and the European Theater of Operations ribbon with four battle participation stars. He also has the following special medal awards: Victory; Occupation; Meritorious Service Unit Plaque; and Glider Wings.

Recent Releases From Service*

Backus, E. A., Milwaukee ---------November, 1945
Becker, W. T., Milwaukee ----------March, 1946
Becker, N. O., Fond du Lac ----------August, 1946
Boyce, D. C., Wauwatosa ----------July, 1946
Britton, D. M., Madison ----------June, 1946
Broderick, C. F., Wisconsin Dells --November, 1945
Buscaglia, A. T., Milwaukee ------November, 1945
Clausen, N. M., Madison ----------August, 1946
Cook, H. E., Milwaukee ----------May, 1946
Davis, L. C., Richland Center ----------June, 1946
Dietz, P. C., Milwaukee ----------August, 1946
Driessel, R. H., West Bend ----------June, 1946
Fine, J. M., Cudahy ----------December, 1945
Fischer, W. A., Madison ----------August, 1946
Garland, J. G., Milwaukee ----------May, 1946
Garrison, R. E., Wisconsin Rapids ------June, 1946
Goodman, P. P., Milwaukee -------December, 1945
Gordon, E. S., Madison ----------February, 1946
Gorenstein, L. M., DeSoto ----------August, 1946
Gundersen, T. E., La Crosse ------December, 1945
Hollenbeck, S. W., Milwaukee ------January, 1946
Ingwell, C. L., Deerfield ----------March, 1946
Johnson, F. C., Wausau ----------March, 1946
Kastl, K. G., Granton ----------April, 1946
Kauth, C. P., Port Washington ---------May, 1946
Kierzkowski, C. V., Beaver Dam --------May, 1946
Klepfer, F. J., Waupun ----------July, 1946
Kocovsky, E. C., Wauwatosa ---------March, 1946
Lee, H. J., Oshkosh ----------May, 1946
Mellencamp, F. J., Milwaukee ----------July, 1946
Merline, G. B., Green Bay ----------August, 1946
Mookerjee, M. K., Milwaukee --------August, 1946
Niver, E. O., Eau Claire ----------June, 1946
Okagaki, H. I., Madison ----------June, 1946
Oosterhous, G. E., Madison ----------July, 1946
Ovitt, D. W., Milwaukee ----------December, 1945
Owen, G. C., Oshkosh ----------April, 1946
Parks, S. L., Milwaukee ----------July, 1946
Postorino, J. D., Racine ----------September, 1946
Radewan, M. G., Madison ----------July, 1946
Rhea, C. W., Wood ----------April, 1946
Rosenberger, A. I., Milwaukee ------January, 1946
Ross, M. E., Beloit ----------December, 1945
Rounds, W. M., Wausau ----------July, 1946
Sanfelippo, A. J., Milwaukee ----------May, 1946
Savage, G. F., Milwaukee ---------December, 1945
Schoenkerman, B. B., Milwaukee ---February, 1946
Schrank, R. E., Waupun ----------February, 1946
Shabart, E. J., Milwaukee ----------August, 1946
Skibba, J. P., Milwaukee ----------May, 1946
Stevenson, D. J., Poynette ----------July, 1946
Stoops, C. W., Jr., Platteville ----------June, 1946
Veit, Henry, Milwaukee ----------September, 1946
Wagner, R. F., Oshkosh ----------May, 1946

* Members of the State Society listed in boldfac

Dependable Nourishment

DURING THAT
all-important
FIRST YEAR OF LIFE

The well nourished baby is more resistant to the common ills of infancy. Moreover it is during that all-important first year of life that the very foundation of *future* health and ruggedness is laid. Similac-fed infants are notably well nourished; for Similac provides breast milk proportions of fat, protein, carbohydrate and minerals, in forms that are physically and metabolically suited to the infant's requirements. Similac dependably nourishes the bottle fed infant —*from birth until weaning.*

ACCEPTED AMERICAN MEDICAL ASSN

A powdered, modified milk product especially prepared for infant feeding, made from tuberculin tested cow's milk (casein modified) from which part of the butter fat is removed and to which has been added lactose, olive oil, cocoanut oil, corn oil and fish liver oil concentrate.

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VETERAN PHYSICIANS' EXCHANGE

This page will be devoted to a classified section, open without charge to: (a) veteran members desiring location and (b) other members having professional openings suitable for men returning from military service.

LOCATIONS WANTED

LOCATION WANTED: General surgeon, 36, who has completed first part of American Board examinations, served in charge of general surgery section in general hospital while in the Army, and is licensed in Wisconsin and Minnesota, desires clinic connection in this region. Will also consider association with internist or small group on a share office basis. Available about August 1. Address No. 129 in care of the Journal.

LOCATION WANTED by young, married, Protestant doctor of Norwegian descent. Has done general practice in small country town for past 8 years. Two years Army service with honorable discharge. Graduate of a class A medical school and at present practicing at location occupied prior to Army service. Desires association with busy doctor doing own surgery in small city with hospital facilities. References gladly exchanged. Personal interview can be arranged. Address No. 130 in care of the Journal.

ASSOCIATION WANTED: Navy veteran (2 yrs), age 27, discharged in July, a graduate of the University of Wisconsin in 1943, desires association or assistantship with qualified surgeon or established general practitioner, leading to partnership. Address No. 134 in care of the Journal.

WANTED: Location or association, by veteran physician with 2 years general practice and over 2 years experience in general and orthopedic surgery in overseas general hospital. Prefer town with population over 2,500. Housing needed for family. Address No. 132 in care of the Journal.

LOCATION WANTED: Veteran physician with 2 years Army service, married, and former resident of Milwaukee desires an assistantship with an obstetrician preferably in Milwaukee. Graduate of Marquette University in 1943, and rotating internship at St. Agnes Hospital, Fond du Lac, Wis. Eligible for release from the Army in November, 1946. Address No. 133 in care of the Journal.

ASSISTANCE WANTED

ASSISTANT WANTED: Young man well trained in obstetrics and surgery for assistantship with busy general practitioner located in the heart of Milwaukee. Office well equipped and staffed. Association on increasing percentage, leading to partnership. Address No. 127 in care of the Journal.

VETERAN PHYSICIANS: This is a strategic time to enter public health. State Board of Health has 2 openings for physicians with executive ability as directors of the tuberculosis and venereal disease divisions. Salary $4,800 to $5,400 plus necessary traveling expenses, Madison headquarters. 5 district health officers also needed. If you were under 40 when entering the armed services and can otherwise qualify, write Dr. Carl N. Neupert, State Health Officer, Madison 2, Wisconsin.

WANTED: Staff physician at sanatorium approved for tuberculosis residency. Beginning salary $250–$300, less modest maintenance deduction. One position open after July 1. Wisconsin licensure required. Person must have good professional and personal qualities. Write Superintendent, Wisconsin State Sanatorium, Statesan, Wisconsin.

For additional classified advertisements, see the Physicians' Exchange, page 938

SOCIETY PROCEEDINGS

Green

The Green County Medical Society, including *Drs. S. J. Francois* and *Earl V. Hicks*, both of New Glarus, were hosts to a large group of physicians at a dinner program August 15, preceding the New Glarus centennial celebration. Special guests at the dinner, musical program, and speeches, held in the William Tell Hotel, New Glarus, were the following natives of that community: *Drs. Palmer Kundert*, Madison; *Fred Kundert*, Monroe; *John Schindler*, Monroe; *Samuel Freitag*, Janesville; C. A. Hefty and Veronica Dolch, Los Angeles; Adolph Kammer, Chicago; Walter Kammer, Muncie, Indiana; and Huldreich Kammer, Cleveland.

Dr. Eben J. Carey, dean of the Marquette University School of Medicine, was the main speaker of the evening. Addresses were also presented by Mr. Leo G. Massopust of the Marquette staff, "Infrared Photography as Applied to Medicine," and "Recent Advances in the Study of Cancer in Medicine," by *Dr. Joseph J. Gramling, Jr.*, also of the Marquette staff.

Monroe

The Monroe County Medical Society, at a meeting held August 21, elected the following officers: *Drs. H. H. Williams Jr.*, Sparta, president; *H. H. Williams Sr.*, Sparta, secretary and treasurer; *Judson S. Allen*, Norwalk, delegate; and *George C. Devine*, Ontario, alternate.

American Cancer Society

An all state conference and training school for the Wisconsin Division of the American Cancer Society was held September 12 and 13, at Northern Baptist Assembly (Formerly Lawsonia), Green Lake.

Among those participating in a forum on cancer detection centers in Wisconsin, Friday afternoon, September 13, conducted by *Dr. A. R. Curreri* of the University of Wisconsin Medical School, were: *Drs. G. L. McCormick*, Marshfield; *J. L. Ford*, Green Bay; *W. T. Clark*, Janesville; *A. L. Mayfield*, Kenosha; and *J. C. Fox*, La Crosse.

INTERNATIONAL SURGICAL ASSEMBLY

UNITED STATES CHAPTER, INTERNATIONAL COLLEGE OF SURGEONS

MASONIC TEMPLE, DETROIT, OCTOBER 21, 22, 23, 1946

President, Herbert Acuff, Knoxville, Tenn. President-Elect Custis Lee Hall, Washington, D. C., Secretary & Chairman Detroit Assembly, L. J. Gariepy, 16401 Grand River Avenue, Detroit 27.

ALL MEDICAL MEN AND WOMEN IN GOOD STANDING CORDIALLY INVITED

Intensive Clinical and Didactic Program by World Authorities

Operative Surgical Clinics, Monday Morning, October 21 in fifteen Detroit hospitals.

Convocation Speakers: Former Ambassador to Japan Joseph C. Grew, Congressman George A. Dondero from Michigan.

Banquet Speakers: Fleet Admiral Chester W. Nimitz, Vice Admiral Ross T. McIntire, Surgeon General of the Navy, and Morris Fishbein, M. D.

The following is list of members of the profession who will take part in program:

Lyon H. Appleby, Vancouver, B. C.
E. B. Astwood, Boston
Hamilton Bailey, London, Eng.
W. Wayne Babcock, Philadelphia
Harry E. Bacon, Philadelphia
Cbanning W. Barrett, Chicago
Moses Bebrend, Philadelphia
A. A. Berg, New York
Jacob Bitscbai, Alexandria, Egypt
Gerald L. Burke, Vancouver, B. C.
Sebastian J. Carnazzo, Omaha, Nebr.
Felipe Carranza, Buenos Aires, Argentina
Alejandro Ceballos, Buenos Aires, Argentina
David deSanson, Rio de Janeiro, Brazil
Francisco Grana, Lima, Peru
J. P. Greenhill, Chicago, Ill.
E. S. Gurdjian, Detroit
Custis Lee Hall, Washington, D. C.
Stuart W. Harrington, Rochester, Minn.
Chas. G. Heyd, New York
Rudolph Jaeger, Philadelphia
Albert Jirasek, Prague, Czechoslovakia
Charles G. Johnston, Detroit
Wm. E. Johnston, Detroit
Herbert I. Kallet, Detroit
Roland M. Klemme, St. Louis
Lloyd G. Lewis, Baltimore
Lowrain E. McCrea, Philadelphia
Wm. C. MacCarty, Rochester, Minn.
Raymond W. McNealy, Chicago
Karl A. Meyer, Chicago
J. H. Mulholland, New York
Rudolf Nissen, New York
Ricbard H. Overholt, Brookline, Mass.
Col. John F. Pick, Chicago, Ill.
Carl A. Rosenbaum, Little Rock, Ark.
Max Thorek, Chicago, Ill.
Harold C. Voris, Chicago, Ill.
Robertson Ward, San Francisco
James M. Winfield, Detroit
Otis R. Wolfe, Marshalltown, Iowa
Edwin L. Zander, New Orleans

Hotel Headquarters: Book-Cadillac Hotel and Statler Hotel. FOR HOTEL RESERVATIONS, write C. W. Husband, Chairman, Housing Committee, 1005 Strob Bldg., Detroit 26, Mich.

Any doctor of medicine who uses surgery in his practice will find this meeting of great value.
A program will be mailed to every member of the medical profession in good standing in the United States and Canada, upon request to the Secretary, about October 1.
COMPREHENSIVE SCIENTIFIC AND TECHNICAL EXHIBIT. SPECIAL ENTERTAINMENT FOR THE LADIES.

THIRD DISTRICT PHARMACISTS

The pharmacies listed in this section have been recommended as rendering the type of prescription service in keeping with high medical standards.

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602 First Central Building
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RELIABLE PRESCRIPTION SERVICE

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Prescription Druggist
3410 Monroe Street, Madison, Wisconsin
Phone: Fairchild 3400

Ampoules, Biologicals, Chemicals, Bacteriological Stains, Trusses, Camp Surgical Supports, "Leeches"
THE PRESCRIPTION PHARMACY
Samuel R. Chechik, Ph.D.
20 South Carroll St. Phone: Badger 755
"The Park Hotel Building", Madison 3, Wis.

Prescription Service at
RENNEBOHM
Better Drug Stores
is always
100% Dependable
Madison, Wisconsin

★ ROCK COUNTY ★

DREKMEIER DRUG
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Beloit, Wisconsin

Two of the guest speakers Friday were *Dr. W. D. Stovall*, director of the State Laboratory of Hygiene, Madison, and Dr. H. P. Rusch, director of research at McArdle Institute, Madison.

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Surgical Assembly Scheduled

An international surgical assembly, sponsored by the United States Chapter, International College of Surgeons, will be held in Detroit, from October 21 through October 23, 1946. An intensive and didactic program by world authorities is planned, and all medical men and women are invited by the College to attend. Sixty scientific speakers from the United States, Europe, and South America will present papers at the twenty-four meetings scheduled. Programs and information on the assembly and the primary qualifications for fellowship in the International College of Surgeons may be secured by writing to L. J. Gariepy, M. D., Secretary, 16401 Grand River, Detroit 27, Michigan.

—△—

Congress on Industrial Health Holds Annual Meeting

The Seventh Annual Congress on Industrial Health, sponsored by the Council on Industrial Health of the American Medical Association, will be held at the Copley–Plaza Hotel in Boston, from September 30 through October 2. *Dr. D. E. Dorchester* of Sturgeon Bay is planning to attend the events of the three days which are scheduled as follows:

Monday, September 30

Clinical Toxicological Conference--------All Day
Lead Poisoning
Surgical Conference----------Afternoon
The Foot in Industry
Professional Relations Conference and Dinner
----------Evening

Tuesday, October 1

Opening General Session----------Morning
Topic—Human Relations in Industry
Elective Seminars----------Afternoon
Section A—Industrial Physiology
Section B—Administrative Methods
Section C—Workmen's Compensation
Dinner and Conference on Pan-American Industrial Health----------Evening

Wednesday, October 2

General Session----------Morning
Atomic Energy—Its Effects in Industry and Medicine
General Session----------Afternoon
A Positive Health Program for Industry
Dinner and Conference on Health and Welfare ----------Evening
Programs in Industry

International Medical Assembly

One Wisconsin physician will participate in the International Medical Assembly October 15 through October 18 in Cleveland, Ohio. The meetings of the Assembly, conducted by the Interstate Postgraduate Medical Association of North America, will be held in the Public Auditorium.

During the October 15 afternoon scientific session *Dr. Eben J. Carey*, dean of the Marquette University School of Medicine, Milwaukee, will present an address entitled, "Progressive Muscular Dystrophy." Two physicians who were in Madison during the war will also take part in the scientific and clinical sessions. Dr. Charles S. Higley, former chief of staff, Army Air Forces Hospital, Truax Field, Madison, who is now on the medical faculty of Western Reserve University, Ohio, will speak on "Recent Advances in the Control of Rheumatic Fever" October 16, and Dr. Bernard B. Larsen, former chief surgeon at Truax Field and now also at Western Reserve University is scheduled to present a diagnostic clinic: "Selection of Cases for Gastric Surgery," October 18.

—△—

Members of the Wisconsin Urological Society wish to welcome back all urologists who have been in military service. If any of the many new urologists now in the state are interested in membership in the Wisconsin Urological Society, they may contact *Dr. Charles R. Marquardt*, Secretary, 324 East Wisconsin Avenue, Milwaukee, Wisconsin.

SOCIETY RECORDS

New Members

D. R. Werba, Veterans Administration, Wood.
C. T. Ziegler, 6301 Washington Circle, Wauwatosa.
D. D. Feld, Muirdale Sanatorium, Wauwatosa.
F. J. Stoddard, 2914 North Summit Avenue, Milwaukee.
G. W. Dean, 1545 South Layton Boulevard, Milwaukee.
P. J. Mateicka, 1545 South Layton Boulevard, Milwaukee.
A. A. Cervenansky, 308 West North Avenue, Milwaukee.
A. J. Krygier, 1128 West Mitchell Avenue, Milwaukee.
H. J. Apfelberg, 2218 North Third Street, Milwaukee.

Changes in Address

Henry Veit, Milwaukee, to 2618 South High Street, Denver, Colorado.
May R. Wells, Madison, to 204 South Jackson Street, Belleville, Illinois.
B. J. Axel, Madison, to 217 East Seventh Street, Temple, Arizona.
L. S. Shemanski, Appleton, to 169 Main Street, Menasha.
W. C. Keettel, Oak Ridge, Tennessee, to OB and GYN Dept., S. U. I. Hospital, Iowa City, Iowa.

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ESTINYL, a derivative of the true follicular hormone, is a highly potent oral estrogen. Relief of menopausal symptoms and other manifestations of estrogen deficiency can be obtained conveniently, rapidly and economically with small doses—usually one 0.05 mg. tablet once or twice daily. In therapeutic dosage most patients experience a feeling of well-being, and undesirable side effects are relatively infrequent.

ESTINYL Tablets: Available in 0.05 mg. and 0.02 mg. in bottles of 100, 250 and 1000 tablets.

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F. G. Gaenslen, Oakland, California, to RR No. 4, Freeport, Illinois.

H. C. Rosenstiel, Sheboygan, to 20 Greenough Place, Newport, Rhode Island.

J. P. Semmens, Ithaca, New York, to 414 Grace Street, Waupun.

R. G. Mayer, Kaukauna, to Veterans Hospital, Wood.

G. C. Owen, Racine, to 3225 Ellicott Street, N. W., Washington, D. C.

E. J. Shabart, Milwaukee, to 1427 Wicker Park Avenue, Chicago 22, Illinois.

F. D. Geist, Madison, to Box 133, Wellfleet, Massachusetts.

J. A. Morton, Madison, to 4500 Beach Road, Birmingham Route 2, Michigan.

C. F. Glienke, Fond du Lac, to 1153 Shorewood Ext., Brooklyn, New York.

F. M. Dowiasch, Madison, to Alma.

M. F. Greiber, Madison, to 420 West Washington Street, Muncie, Indiana.

J. C. Colignon, Green Bay, to 720 North Broadway, De Pere.

Milton Trautmann, Madison, to Prairie du Sac.

L. V. Bergstrom, Vancouver, Washington, to Route 11, Ridgefield, Washington.

H. J. Zotter, Milwaukee, to 5627 North Central Avenue, Chicago 30, Illinois.

Florence I. Mahoney, Madison, to Student Health Service, Pennsylvania State College, State College, Pennsylvania.

A. R. Remley, Union Grove, to Mendota State Hospital, Mendota.

BIRTH

A daughter to Dr. and Mrs. Eugene J. Usow, Milwaukee, on July 17.

DEATHS

Dr. Francis E. Hypes, former Three Lakes physician, died suddenly Saturday, July 13, at his home in Nappanee, Indiana. He was 59 years old.

The doctor attended the Indiana State Normal School and graduated from the Indiana University School of Medicine, Bloomington–Indianapolis, in 1913. He practiced in Three Lakes and then became the physician for various CCC camps throughout the north woods. About four years ago, Doctor Hypes moved to Indiana. He served for three and one-half years in the U. S. Navy at one time.

Doctor Hypes was formerly a member of the Oneida–Vilas County Medical Society and the State Medical Society. He was also a member of the American Medical Association.

Surviving the doctor is his wife.

Dr. Charles A. Balkwill, 61, physician and surgeon in Grafton for thirty-six years, died Monday, July 29, at his home in Grafton after a short illness.

Doctor Balkwill attended the University of Western Ontario Medical School at London, Ontario, where he was graduated in 1907. After serving his internship in Grand Rapids, Michigan, he moved to Grafton and started the practice that he continued until his death.

The doctor was a past-president and member of the Washington–Ozaukee County Medical Society, a member of the State Medical Society, and held a fellowship in the American Medical Association.

He is survived by his wife and one son.

Dr. Ronald S. MacKechnie, 73, of Hillsboro, died at his home Wednesday, August 7, after an illness of several weeks. He had practiced medicine in Hillsboro and vicinity for thirty-eight years.

A native of Brighton, Ontario, the doctor received his degree from the Medical Faculty of Trinity University, Toronto, in 1900. Doctor MacKechnie then went to a corundum mine in central Ontario where he practiced as a mining company physician for five years. While there, he met Dr. Charles Van Hise, president of the University of Wisconsin, who urged him to come to Wisconsin. After taking postgraduate work at Johns Hopkins University School of Medicine in Baltimore, Doctor MacKechnie did move to Wisconsin in 1908 and began his practice in Hillsboro.

He was a member of the Vernon County Medical Society and the State Medical Society, and a Fellow of the American Medical Association. For many years the doctor took an active part in Hillsboro community affairs.

Surviving Doctor MacKechnie are his three daughters.

News Items and Personals

Doctor Quade Addresses Lions Club

Neurosurgeon, *Dr. Raymond H. Quade* of Neenah appeared as guest speaker at the Appleton Lions Club meeting in the Conway Hotel, Appleton, August 19. His talk was entitled, "Relationship of Personality to Mental Health."

Doctor Stein Attends Birth of Triplets

Dr. John F. Stein of Oshkosh realized a lifelong ambition August 4, when he delivered the first set of triplets in his long practice. The babies, two boys and a girl, were born to Mrs. Lester Dehn of Oshkosh.

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For Nervous Disorders

A fifty bed hospital and sanitarium. Separate buildings for neurotic and psychotic cases.

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Jackson Clinic Postgraduate Program

The Jackson Clinic, Madison, is planning another Postgraduate Clinic which will be held Saturday, September 21, the day of the Wisconsin–Marquette football game in Madison.

There will be a program from 8 a. m. until noon, presented by members of the faculty of the Marquette University School of Medicine, other Milwaukee physicians, and the Jackson Clinic staff. After the meeting, physicians and their wives will have lunch at the Hotel Loraine and then attend the football game in a group. The following program has been arranged:

Program—September 21, 1946

8:15 Case Presentations—*Drs. Luther E. Holmgren*, Glen E. Hayden, and Donald R. Davis
8:30 The Use of Gelfoam in Surgery—*Dr. Russell Jackson*
8:40 Diaphragmatic Hernia—Dr. William L. Waskow
9:00 Experiences in the Pacific War Area—*Dr. John T. F. Gallagher*
9:15 Thiouracil and Propylthiouracil in Toxic Goiter—*Dr. Arnold S. Jackson*
9:30 Pseudo-Atrophy—*Dr. Russell Kurten*
9:45 Newer Concepts in the Treatment of Heart Disease—*Dr. Harold E. Marsh*
10:00 Is Cesarean Section Necessary?—*Dr. Henry J. Olson*
10:20 Some Phases of Biliary Surgery—*Dr. Dexter H. Witte*
11:00 Some Acute Cardiac Disturbances—*Dr. William M. Jermain*
11:20 Common Fallacies in the Treatment of Hemorrhagic Diseases—*Dr. Frederick W. Madison*
11:40 Address by *Dr. Eben J. Carey*, Dean of the Marquette University School of Medicine—The Veteran in Relation to Medical Education
12:15 Luncheon at the Hotel Loraine for doctors and their wives
2:00 Marquette–Wisconsin football game

—△—

Medical Man Tells of Polio Situation

Dr. Raymond G. Arveson of Frederic told members of the Frederic Rotary Club of the infantile paralysis situation in Minnesota and northern Wisconsin at their meeting August 19. Doctor Arveson attended a meeting of physicians and others at River Falls the preceding week, where *Dr. S. E. Williams* of Chippewa Falls told of his visit, along with other doctors, to the Kenny Institute and other hospitals in Minneapolis.

—△—

Health Officer Resigns

Dr. Robert C. Wolf of Hales Corners, health officer of the town of Greenfield for the past ten years, resigned his position September 1, in order to devote all his time to private practice.

Brownsville Honors Doctor Raymond

Dr. Rolland G. Raymond, 65, was honored by almost 1,000 former patients and friends at an open house in the Brownsville Community Club Hall, August 15, following a banquet. Doctor Raymond has announced his retirement from active medical service after serving the community of Brownsville and the surrounding area for forty years. At the dinner and open house, gifts were presented to Doctor Raymond, physician and civic leader, by the citizens of Brownsville, the Fond du Lac County Medical Society, the Fond du Lac Clinic, and the White Horse Club. Among the speakers were *Drs. David Twohig*, and *W. H. Folsum*, both of Fond du Lac. A graduate of the Wisconsin College of Physicians and Surgeons in Milwaukee in 1906, the doctor took his internship in Milwaukee and a postgraduate course in obstetrics in Chicago before starting his practice in Brownsville, August 15, 1906.

Among those at the anniversary celebration for Doctor Raymond were *Dr. M. F. Ries*, his associate for eleven years, and *Dr. Leland E. Friedrich*, who will jointly take over the retiring doctor's practice.

Doctor Johnson Joins UW Medical Staff

Notice of the appointment of Dr. Sture A. M. Johnson to the medical faculty of the University of Wisconsin appeared in a list of new appointments in the Medical Forum of the August *Journal*.

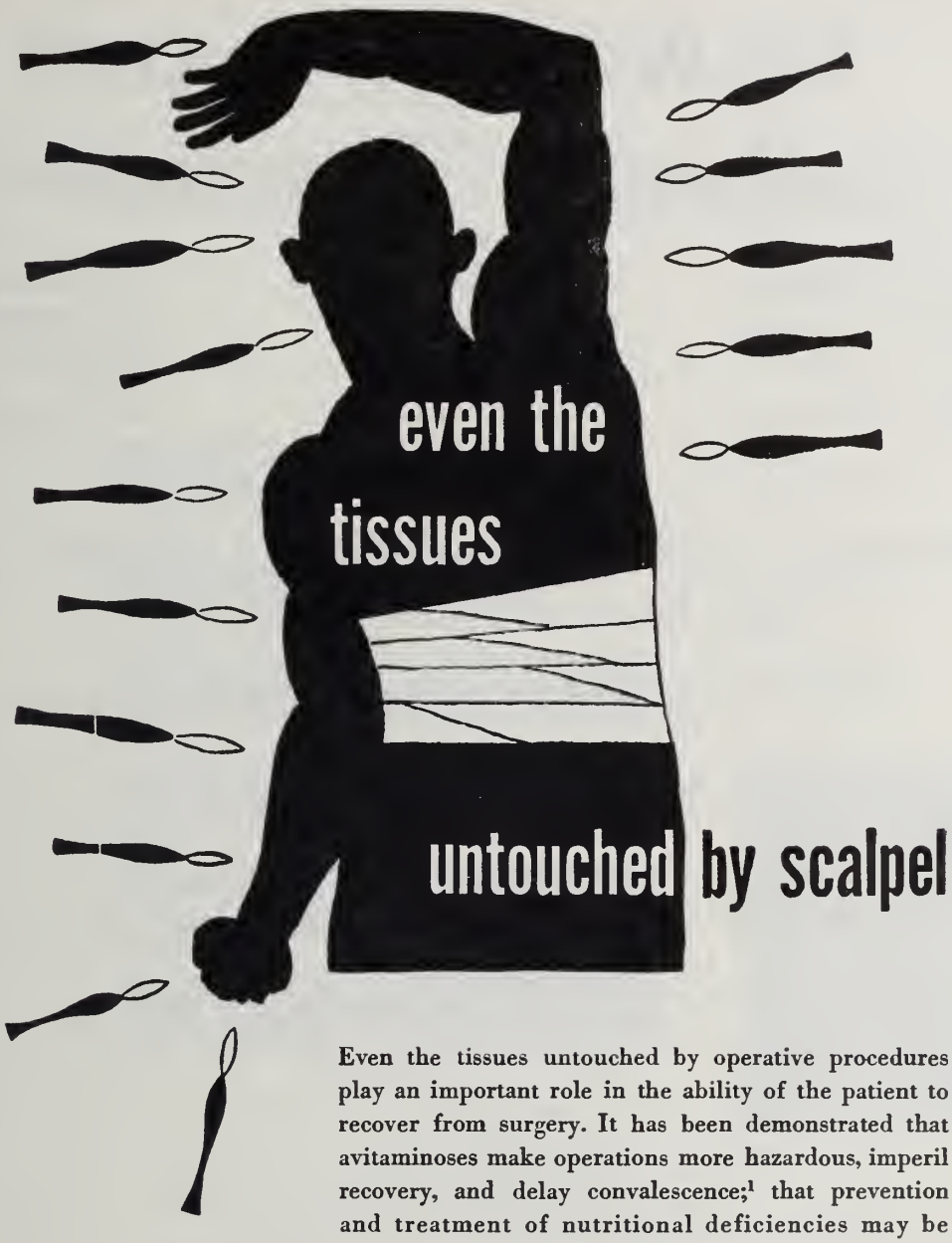
Doctor Johnson, who assumed the post of professor of dermatology and syphilology September 1, 1946, is a graduate of the University of Oregon Medical School and was a resident in dermatology at that institution. Following that service, he did postgraduate study in the field of dermatology and syphilology at the Skin and Cancer Unit of the New York Postgraduate Division of Columbia University. Later he served as assistant professor of dermatology and syphilology at the University of Michigan Medical School, Ann Arbor.

Doctor Johnson is a Diplomate of the American Board of Dermatology and Syphilology and has done extensive work in the field of mycology. His publications and studies cover a broad field and the list includes four that were done in association with Dr. Udo J. Wile of the University of Michigan.

The new faculty member is also a graduate pharmacist. He replaces *Dr. O. H. Foerster*, who retired as head of dermatology and syphilology at the University of Wisconsin to become professor emeritus on July 1, 1946.

Dr. W. T. Clark Named Chief of Staff

At a meeting of the staff doctors of Mercy Hospital, Janesville, on August 8, *Dr. William T. Clark*, Janesville, was elected chief of staff to serve for a period of three years. Doctor Clark has been a practicing physician for thirty-eight years, and is radiologist at Mercy Hospital. He is a member of the State Board of Health, appointed as such by Governor Goodland to serve until 1949.



Even the tissues untouched by operative procedures play an important role in the ability of the patient to recover from surgery. It has been demonstrated that avitaminoses make operations more hazardous, imperil recovery, and delay convalescence;[1] that prevention and treatment of nutritional deficiencies may be "decisive"[2] in recovery following surgery. In the field of oral and parenteral vitamins, Upjohn offers a full range of highly potent, convenient to administer, economical vitamins.

1. Virginia M. Monthly **72**:240 (June) 1945.
2. Am. J. Surg. **54**:299 (April) 1942.

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Mrs. J. R. Minahan, Corresponding Secretary, Green Bay
Mrs. N. A. Hill, Madison, Treasurer

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Hygeia—
Mrs. J. S. Huebner, Fond du Lac

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Mrs. G. J. Pugh, Milwaukee

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Mrs. D. B. Dana, Kewaunee

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Organization—
Mrs. C. N. Neupert, Madison

Eighteenth Annual Meeting Woman's Auxiliary to the State Medical Society of Wisconsin

October 6, 7, and 8, 1946, Hotel Schroeder, Milwaukee

MRS. ARTHUR J. McCAREY
Green Bay
President

Dear Doctor's Wife:

Do you remember when you joined the Woman's Auxiliary? Do you really remember the exact date?

You were a nurse or a secretary or a teacher or a college woman or, perhaps, just a society girl.

And then he came along—that good looking young man with a prescription book in one pocket and a stethoscope casually protruding from the other.

He had that wonderful smile and an air of future success about him—And the way he looked at you, you decided then and there to marry him.

And on that wedding day, you joined the Auxiliary, not officially of course, but you were in there helping from that day forward—answering the telephone, keeping house, having babies and all that.

Later, of course, you helped organize your local Auxiliary or joined the one already formed.

And now, look at all the wonderful things you are doing to help him and his beloved profession.

Well, what I really started out to say was this: You know that there has not been a meeting of the State Medical Society for two whole years.

So . . . we are expecting Dr. and Mrs. Wisconsin to arrive in Milwaukee in October in greater numbers than ever before.

While the Convention is planned *by* the Auxiliary, it is planned *for* all doctors' wives, whether Auxiliary members or not.

Milwaukee is making great plans for you. *Please* do not forget the dates—October 6, 7 and 8.

I am looking forward to our meeting.

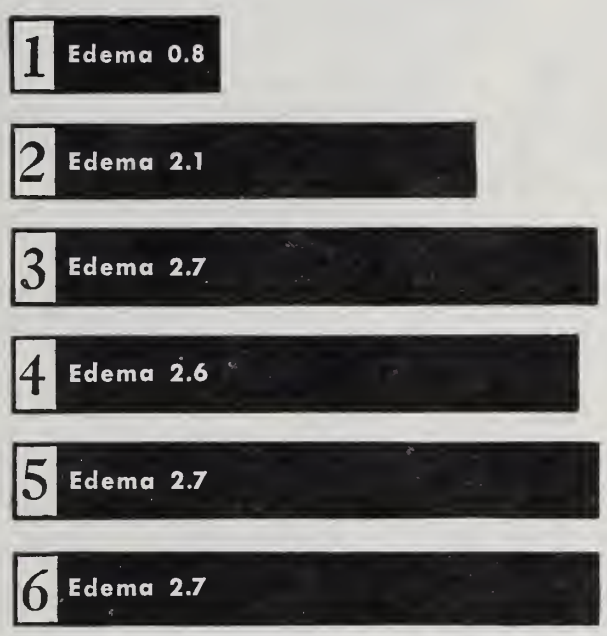
Sincerely,

ARLEEN JOANNES McCAREY, *President.*

(Continued on page 918)

How irritation varies from *different* cigarettes

Tests made on rabbits' eyes reveal the influence of hygroscopic agents*



CONCLUSION:* Results show that regardless of blend of tobacco, flavoring materials, or method of manufacture, the irritation produced by all ordinary cigarettes is substantially the same, and measurably greater than that caused by PHILIP MORRIS.

CLINICAL CONFIRMATION: ** When *smokers* changed to PHILIP MORRIS, substantially every case of irritation of the nose and throat due to smoking cleared completely or definitely improved.

**N. Y. State Journ. Med. 35 No. 11,590 **Laryngoscope 1935, XLV, No. 2, 149-154*

TO THE PHYSICIAN WHO SMOKES A PIPE: We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

MRS. W. C. LIEFERT
Shorewood
Convention Chairman

MRS. J. C. FOX
La Crosse
President-Elect

Program

Sunday, October 6, 1946

P. M.

4:00-6:00 Registration—Fifth Floor, Hotel Schroeder

7:00 Board of Directors' Dinner—Club Rooms, Hotel Schroeder

Mrs. A. J. McCarey, president, presiding

Honored Guests

Past-presidents, Woman's Auxiliary to the State Medical Society of Wisconsin

Reports of state chairmen

Monday, October 7, 1946

A. M.

8:30 Registration and Tickets—Fifth Floor, Hotel Schroeder

10:00 General Meeting—Club Rooms, Hotel Schroeder

Mrs. A. J. McCarey, president, presiding

Invocation—Reverend Meredith M. Hogue, Shorewood Presbyterian Church

Pledge of Allegiance to Flag

Auxiliary Pledge

Convention Announcements—Mrs. W. C. Liefert, chairman

Address of Welcome—Mrs. M. Q. Howard, president, Woman's Auxiliary to the Medical Society of Milwaukee County

Response—Mrs. J. C. Fox, president-elect, Woman's Auxiliary to the State Medical Society of Wisconsin

In Memoriam

Convention Rules and Procedure—Mrs. R. E. Fitzgerald, parliamentarian

Minutes of Annual Meeting, 1945

Reports of State Officers

Reports of County Auxiliary Presidents

Report of Chairman, Committee on Credentials and Registration

P. M.

1:00 Luncheon—Empire Room, Hotel Schroeder

Greetings—Dr. P. R. Minahan, president, State Medical Society of Wisconsin

Style Show

7:00 Buffet Supper—Empire Room, Hotel Schroeder (Courtesy, State Medical Society of Wisconsin)

Reading of a currently popular Broadway play—staged and read by amateur Milwaukee actresses

Tuesday, October 8, 1946

A. M.

10:00 General Meeting—Club Rooms, Hotel Schroeder

Mrs. A. J. McCarey, president, presiding

Business Session
Election of Officers

Induction of the President, Mrs. J. C. Fox

Installation of New Officers

Announcements

Report of Chairman of Committee on Credentials and Registration

11:30 Post-Convention Meeting, Board of Directors—Club Rooms, Hotel Schroeder

Mrs. J. C. Fox, president, presiding

P. M.

1:00 Luncheon—Banquet Room, Hotel Schroeder
Round-Table Discussions—Mrs. Gunnar Gundersen, Toastmistress

Lecture with Movies—"New Horizons for the Handicapped" by representative of The Curative Workshop, Milwaukee

6:45 Informal Banquet, State Medical Society of Wisconsin—Crystal Ballroom, Hotel Schroeder

(Continued on page 920)

This unretouched photomicrograph depicts the pure, crystalline state in which all Penicillin-C.S.C. is now supplied.

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*CAUTION: Once in solution, however, penicillin still requires refrigeration.

Optimal Therapeutic Activity

Because of its high potency per milligram, Crystalline Penicillin Sodium-C.S.C. exerts optimal therapeutic activity. A recent report shows the advantage of highly potent preparations.[1]

Potency Clearly Stated on Label

The high state of purification achieved in Crystalline Penicillin Sodium-C.S.C. is indicated by *its high potency per milligram*. The number of units per milligram is stated on each vial, thus enabling the physician to know the degree of purification of the penicillin he is using.

[1] "The potency of the penicillin undoubtedly affected the results. The first 15 patients, all treated with the same batch of penicillin, were cured. The next 7 patients were treated with the same dosage of a different batch of penicillin. Five of these were not cured. Assays of penicillin used for these 7 patients showed it to be of reduced potency." Trumper, M., and Thompson, G. J.: Prolonging the Effects of Penicillin by Chilling, J.A.M.A. *130*: 628 (March 9) 1946.

Crystalline Penicillin Sodium-C.S.C. is available in serum-type vials containing 100,000, 200,000, or 500,000 units.

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Corresponding Secretary	Mrs. J. R. Minahan, Green Bay
Treasurer	Mrs. N. A. Hill, Madison
Parliamentarian	Mrs. R. E. Fitzgerald, Milwaukee

Delegates and Alternate Delegates to the Eighteenth Annual Meeting of Woman's Auxiliary to the State Medical Society of Wisconsin*

County	President *Mesdames:*	Alternate to President	Delegate	Alternate Delegate
Ashland–Bayfield–Iron	W. J. Tucker	F. D. Weeks	R. O. Grigsby	A. H. Lamal
Brown–Kewaunee–Door	F. L. Crikelair	P. R. Minahan	E. S. McNevins	J. E. Halloin
Columbia–Marquette–Adams	H. E. Gillette	C. W. Henney	E. F. Tierney	R. B. Dryer
Crawford	T. F. Farrell	E. M. Dessloch	G. R. Hammes	O. E. Satter
Dane	C. A. Fosmark	G. A. Cooper	B. I. Brindley	D. L. Williams
Dodge	W. H. Costello	E. H. Federman	G. H. Hoyer	
Fond du Lac	J. J. Rehorst	E. V. Smith, Jr.	E. H. Pawsat	R. L. Waffle
Kenosha	A. F. Rufflo	W. H. Lipman	A. M. Rauch	C. C. Davin
La Crosse	J. R. Richter	G. B. Ridout	Martin Sivertson	M. A. McGarty
Marinette–Florence	H. L. Jorgenson		J. V. May	
Milwaukee	M. Q. Howard	E. J. Carey	W. H. Studley	N. W. Bourne
			E. P. Bickler	C. B. Hake
			S. J. Silbar	J. P. Wild
			B. P. Churchill	R. D. Champney
			M. G. Klumb	E. F. Barta
			H. A. Heise	C. W. Osgood
			E. F. Guy	H. J. Heeb
			Norbert Enzer	
Outagamie	E. N. Krueger	F. J. Huberty	A. C. Taylor	E. J. Zeiss
Polk	W. B. Cornwall	R. G. Arveson	V. C. Kremser	
Racine	E. J. Schneller	I. N. Tucker	R. H. Lehner	W. E. Buckley
Sauk	Milton Trautmann	M. F. Huth	Harry Vander Kamp	Roger Cahoon
Sheboygan	I. M. Bemis	H. J. Hansen	Ludwig Gruenewald	C. M. Yoran
Walworth	J. A. Rawlins	R. C. Halsey	E. D. Sorenson	C. W. Connell
Washington–Ozaukee	K. T. Bauer	C. P. Kauth	F. W. Lehmann	R. F. Raney
Waukesha	W. H. Oatway	W. D. James	Miss Hertha Voje	F. W. Aplin
Winnebago	T. E. Kilkenny	R. H. Bitter	H. W. Kleinschmit	B. J. Hughes

* No reports received from county societies not listed.

The following slate of proposed candidates has been prepared by the Nominating Committee, to be acted upon at the annual election of officers, October 8, 1946:

President-elect—Mrs. A. W. Hammond, Beaver Dam

Vice-President—Mrs. E. P. Bickler, Milwaukee

Secretary—Mrs. H. W. Kleinschmit, Oshkosh

Treasurer—Mrs. N. A. Hill, Madison

(Continued on page 922)

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Mrs. J. P. Conway, program chairman
Mrs. J. L. Garvey, program co-chairman
Mrs. U. A. Schlueter, social chairman

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Mrs. J. P. Wild, co-chairman

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Mrs. W. F. Grotjan
Mrs. V. F. Lang
Mrs. A. F. Tessier
Mrs. S. A. Morton
Mrs. S. F. Morgan

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Mrs. G. H. Hoffmann, co-chairman
Mrs. E. P. Bickler
Mrs. E. J. Behnke
Mrs. R. C. Pfeil
Mrs. J. L. Kruszewski
Mrs. J. M. Jekel

Publicity

Mrs. T. M. Northey, chairman
Mrs. G. J. Pugh

Convention Hall

Mrs. S. G. Higgins, chairman
Mrs. L. T. Servis, co-chairman
Mrs. Carroll Brooks
Mrs. R. A. Jefferson
Mrs. Vernon Kores
Mrs. R. T. Rank
Mrs. M. J. Murphy
Mrs. D. A. Morrison
Mrs. A. D. Bussey

Flowers

Mrs. M. G. Klumb, chairman
Mrs. G. J. Gumerman, co-chairman
Mrs. J. J. Wilkinson
Mrs. P. A. Lee
Mrs. J. V. Heil
Mrs. L. C. Massopust

Information

Mrs. R. H. Frederick, chairman
Mrs. A. H. Hermann, co-chairman
Mrs. W. J. Scollard
Mrs. E. A. Brzezinski
Mrs. J. W. Fons
Mrs. H. J. Gramling
Mrs. J. A. Jenner
Mrs. H. P. Siekert

Hostesses

Officers and Members of the Board of Directors of The Woman's Auxiliary to the Medical Society of Milwaukee County:
Mrs. M. Q. Howard, president
Mrs. W. H. Studley, president-elect
Mrs. H. A. Heise, past-president
Mrs. E. P. Bickler, vice-president
Mrs. B. P. Churchill, corresponding secretary

Hostesses—Continued

Mrs. M. G. Klumb, recording secretary
Mrs. S. J. Silbar, treasurer
Mrs. R. E. Fitzgerald, director
Mrs. Norbert Enzer, director
Mrs. E. F. Guy, director
Mrs. N. W. Bourne, director
Mrs. C. B. Hake, director
Mrs. J. P. Wild, director

Board of Directors Dinner, Sunday, October 6

Mrs. H. J. Heeb, chairman

Luncheon, Monday, October 7

Mrs. E. G. Nadeau, Green Bay, chairman
Mrs. F. R. Janney, co-chairman
Mrs. E. J. Carey, co-chairman

Style Show

Mrs. H. A. Heise, chairman
Mrs. R. E. McDonald, co-chairman

Hostesses

Mrs. L. D. Quigley, Green Bay
Mrs. P. R. Minahan, Green Bay
Mrs. J. R. Minahan, Green Bay
Mrs. E. S. Schmidt, Green Bay
Mrs. R. B. Lenz, West De Pere
Mrs. R. W. Burns, Green Bay
Mrs. D. B. Dana, Kewaunee
Mrs. V. J. Shippy, Pulaski
Mrs. E. F. Peterson
Mrs. John McCabe
Mrs. Charles Fidler
Mrs. R. D. Bergen
Mrs. M. J. Reuter

Supper and Entertainment, Monday, October 7

Mrs. W. M. Jermain, chairman
Mrs. D. H. Witte, co-chairman
Mrs. G. H. Larson, co-chairman

Hostesses

Past-Presidents of Woman's Auxiliary to the Medical Society of Milwaukee County:
Mrs. J. C. Sargent
Mrs. J. G. Taylor
Mrs. H. J. Heeb
Mrs. E. J. Carey
Mrs. R. G. Washburn
Mrs. R. E. McDonald
Mrs. C. D. Partridge
Mrs. R. D. Champney
Mrs. H. O. Zurheide
Mrs. E. F. Barta
Mrs. H. F. Heise
Mrs. M. Q. Howard

Luncheon, Tuesday, October 8

Mrs. J. R. Richter, Chaseburg, chairman
Mrs. J. J. McGovern, co-chairman

Hostesses

Mrs. G. D. Reay, Onalaska
Mrs. J. E. McLoone, La Crosse
Mrs. F. H. Wolf, La Crosse
Mrs. G. B. Ridout, La Crosse
Mrs. F. C. Heidner
Mrs. R. P. Sproule
Mrs. Irwin Schulz
Mrs. G. W. Neilson
Mrs. V. L. Baker
Mrs. R. W. Blumenthal
Mrs. P. R. Currer
Mrs. H. W. Strass

a Poor Scholar . . . because of a Poor Breakfast

MANY a child is scolded for dullness when he should be treated for undernourishment. In hundreds of homes a "continental" breakfast of a roll and coffee is the rule. If, day after day, a child breaks the night's fast of twelve hours on this scant fare, — or less — small wonder that he is listless, nervous, or stupid at school.

Pablum offers a happy solution to the problem of the school-child's breakfast. Mothers who learn about Pablum from their physicians are delighted to serve it, for it needs no cooking and can be prepared in a minute at the table — more quickly than many less nourishing foods. Right now, this feature is especially valuable in homes where the mother is engaged in war work. Pablum not only ends the bane of long cooking of cereals but in addition furnishes a variety of minerals (calcium, phosphorus, and iron) and the vitamin B complex. It is an excellent vehicle for milk.

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The Journal Bookshelf

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, S. M. I. Building, Madison, Wis.

Bacillary Dysentery Colitis and Enteritis. By Joseph Felsen, B. A., M. D., Director of Medical Research, Bronx Hospital, New York; Director of International and Pan-American Dysentery Registry. Pp. 618 with 145 illustrations. Philadelphia and London: W. B. Saunders Company, 1945. Price $6.00.

In this comprehensive treatise of enterocolitis, the author develops the thesis of the inter-relationship of chronic ulcerative colitis and regional ileitis with bacillary dysentery.

Convincing as his evidence seems to be, it does not seem likely that there will be universal acceptance of his belief that the chronic infectious processes of the intestinal tract, which heretofore have been of indeterminate cause, are actually in the nature of chronic bacillary dysentery following in the wake of acute bacillary dysentery.

The book is most complete in the presentation of both clinical and laboratory material. It will be of interest especially to the gastro-enterologist, to the clinical pathologist, to the practitioners of medicine confronted with the dysenteries, and to the proctologist. It should be in every medical library as a reference book.

In Wisconsin, it is difficult to appreciate the significance of bacillary dysentery, for here, in a rural northern area of relatively sparse population, the bacillary dysenteries do not exist to the same extent as in the urban, densely populated areas. K. L. P.

Clinical Traumatic Surgery. By John J. Moorhead, B. S., M. D., D. Sc., F. A. C. A. (D. S. M.), formerly Professor of Clinical Surgery, New York Post-Graduate Medical School, Columbia University, and Executive Officer, Department of Traumatic Surgery, Post-Graduate Hospital and Reconstruction Hospital Unit; Diplomate in Surgery; Colonel, Medical Corps (A. U. S.) Inac. Res.: Medical Director, New York City Transit System. Consulting Surgeon, Post-Graduate Hospital, U. S. Public Health Service, All Souls (Morristown), Anne May Memorial (Spring Lake), Caledonian, Harlem, Mary Immaculate (Jamaica), Mother Cabrini, New Rochelle, Nyack, Rockland State, St. Francis (Port Jervis), and Yonkers General Hospitals. Pp. 747 with 500 illustrations. Philadelphia and London: W. B. Saunders Company, 1945. Price $10.00.

This monograph devoted to traumatic surgery is an excellent introduction to this field for the general practitioner or for young men who plan to devote their full time to this work. The author presents in a simple manner the fundamentals and principles involved in this specialized type of surgery. Sufficient detail is given to therapy to make this work very useful. A. R. C.

The Extremities. By Daniel P. Quiring, Ph. D., Head of the Anatomy Division, Cleveland Clinic Foundation, and Associate Professor of Biology, Western Reserve University; Beatrice A. Boyle, artist, Cleveland Clinic Foundation; Erna L. Boroush, M. A., Fellow Anatomy Division, Cleveland Clinic Foundation; and Bernardine Lufkin, A. B., Former Secretary, Research Division, Cleveland Clinic Foundation. Pp. 117 with 106 engravings. Philadelphia: Lea & Febiger, 1945. Price $2.75.

This volume is chiefly of value to the student, especially of physical therapy. It consists of clear cut, diagrammatic drawings of the individual muscles of both extremities. There are brief descriptions of their origins, insertions, functions and nerve and arterial supply. The motor points of each muscle are also illustrated.

It should be in the library of every physical therapy department, and could well be used by others for quick reviews of the myology of the extremities. A. E. C.

Physiotherapy—A Monograph. By Thomas Francis Hennessey, M. D., Dean and Director, Massachusetts School of Physiotherapy, Boston. Pp. 23. Boston: Bellman Publishing Company, Inc., 1946. Price $.75.

This pamphlet describes in a general way the field of physical medicine, a brief history of its development and a few of the vocational opportunities for both physicians and technicians.

The section describing schools offering physical therapy training and requirements for admission to these schools is so inaccurate that it is worthless.

Clinical Biochemistry. By Abraham Cantarow, M. D., Professor of Physiological Chemistry, Jefferson Medical College; formerly Associate Professor of Medicine, Jefferson Medical College, and Assistant Physician, Jefferson Hospital; and Max Trumper, Ph. D., Lt. Commander, H(S), USNR, Naval Medical Research Institute, National Naval Medical Center, Bethesda, Md.; formerly in charge of the Laboratories of Biochemistry of the Jefferson Medical College and Hospital. Third edition, revised. Pp. 647 with 29 illustrations. Philadelphia and London: W. B. Saunders Company, 1945. Price $6.50.

The third edition, revised, of Cantarow and Trumper's *Clinical Biochemistry* is a valuable volume for the clinician. This is not a laboratory manual, but rather a successful effort at correlating biochemistry and physiology with clinical problems. In spite of the rapid advances in biochemistry and physiology in recent years, the authors have succeeded admirably in staying abreast of the times. The scope of this book can be appreciated from the fact that the following topics are discussed: protein, carbohydrate, fat, and mineral metabolism; acid-base and water balance; respiratory exchange and basal metabolism; vitamins; hormone assay and endocrine function; cerebrospinal fluid and biochemical changes in pregnancy and lactation. An outline of the chemical abnormalities which might be found

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in various diseases is given with page references to the detailed discussions in the text.

A well chosen and up-to-date bibliography is included at the end of each chapter. The text is well written and indexed. This book is recommended particularly to the clinician who is interested in keeping abreast of biochemical developments in relation to disease. P. P. C.

Internal Medicine, Its Theory and Practice. Edited by John H. Musser, B. S., M. D., F. A. C. P., Professor of Medicine in the Tulane University of Louisiana School of Medicine; Senior Visiting Physician to the Charity Hospital, New Orleans, Louisiana. Cloth. Pp. 1518 with illustrations (photographs, maps, charts, tables). Philadelphia: Lea & Febiger, 1945.

The new fourth edition of *Internal Medicine,* edited by Dr. John Musser, reflects very well the changing times in which we are living from a medical point of view. It is a larger book by almost 200 pages than the last edition and much of this is taken up by adequate coverage of the newer therapeutic agents including the sulfonamides, penicillin, and thiouracil. The problems brought on by the war also account for a certain increase in size, notably sections on protozoan and metazoan diseases as well as articles on military neuropsychiatric disabilities, war neurology, and a section on altitude sickness. Death or retirement necessitated changes in authors of several chapters and in others revisions were necessary because of the change in material. Among those chapters re-written we might note were diseases of the locomotor system, the section on rickettsial diseases, portions of the chapter on contagious diseases of childhood, and the section on diseases of unknown etiology. The book lives up to the original purposes, namely, to give to the undergraduate students an authoritative textbook containing the essentials and to the practitioner of medicine a ready reference properly documented with an adequate bibliography so that, if he desires, he can go to the source of material for more detailed information. The book, as did the previous editions, lives up to these ideals quite adequately. C. J. T.

Common Ailments of Man. Edited by Morris Fishbein, M. D., Editor, Hygeia, The Health Magazine. Pp. 177. No illustrations. New York: Garden City Publishing Co., Inc., 1945. Price $1.00.

A book designed primarily for the layman, *Common Ailments of Man* explains simply and clearly the common characteristics as well as the means which are available to the physician to combat some of the ills which most frequently bring the patient to the physician. It is edited by Dr. Morris Fishbein and the sections are written by leading authorities in the various fields covered. As an example, Dr. Chester Keefer explains facts on common colds and respiratory infections, Dr. Paul White, on heart disease. The articles were originally published in *Hygeia.* Unlike the usual book of this type, the *Common Ailments of Man* stresses the implication of the condition, that it may be a danger signal or symptom of a very serious ailment and that consultation with a physician is necessary for many of them. It can be recommended to persons interested in reading on health subjects, may be recommended to patients because of a specific chapter treating an ailment which the patient possesses, and it may furnish the physician with an idea as to just how to explain the various illnesses to his patient. C. J. T.

Year Book of Obstetrics and Gynecology. Edited by J. P. Greenhill, B. S., M. D., F. A. C. S., Professorof Gynecology, Cook County Graduate School of Medicine; Chairman, Department of Gynecology, Cook County Hospital; Attending Obstetrician and Gynecologist, Michael Reese Hospital; Associate Staff, Chicago Lying-In Hospital. Pp. 576 with 114 illustrations. Chicago: The Year Book Publishers, Inc., 1945. Price $3.00.

The Yearbook of Obstetrics and Gynecology needs no defense for its publication. It is an excellent book, reviewing in short all the worthwhile articles that have been written over a yearly period. I highly recommend this edition. R. E. C.

The Analysis and Interpretation of Symptoms. Edited by Cyril M. MacBryde, M. D., assistant professor of clinical medicine, Washington University School of Medicine; director, metabolism division, Barnes Hospital, St. Louis, Missouri. Contributors: Paul B. Beeson, M. D.; Richard H. Freyberg, M. D.; Edwin F. Gildea, M. D.; Sara M. Jordan, M. D.; Sidney A. Portis, M. D.; Leon Schiff, Ph. D., M. D.; David M. Skilling, M. D.; John R. Smith, M. D.; Harold G. Wolff, M. D. Cloth. Pp. 201 (reprinted from *Clinics,* April, 1944); Vol. II, No. 6. Philadelphia: J. B. Lippincott Company, 1944. Price $4.00.

In contrast to most textbooks which begin with the symptomatology of disease entities, this small book treats in a concise and yet complete manner the mechanisms and work in the production of various important symptoms as well as the etiologic factors one must consider in evaluating each. The book is divided into ten sections which include nervousness and fatigue; fever; headache—its mechanisms and differential diagnosis; cough and hemoptosis; thoracic, abdominal and joint pains; hematemesis and

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melena; jaundice; and obesity. Each is written by a recognized authority, the names appearing above. It again accentuates the importance which we must place on a carefully taken history and should be of value to the practicing physician as well as to the medical student who is studying physical diagnosis. It emphasizes not only correlation between symptoms but the pathologic physiology of the symptoms as well as physical and laboratory evidence which is, of course, important but secondary in the diagnostic method. This monograph should stimulate both critical and analytic thinking for anyone spending time with it. It is fundamental and provides easy reading on the subjects considered. C. J. T.

Synopsis of Physiology. By Rolland J. Main, Ph. D., Professor of Physiology, Medical College of Virginia, Richmond. Pp. 341 with 21 illustrations. St. Louis, The C. V. Mosby Company, 1946. Price $3.50.

This is an excellent synopsis of physiology. It is unusually complete and makes interesting reading. In a concise, brief form the various direct clinical applications of physiology are pointed out. Since the table of contents is very extensive and the index quite complete, it is very easy to find the discussion of any particular topic. This book is well suited for a review outline of the essentials of physiology.—R. C. H.

Essentials of Neuro-Psychiatry. A Textbook of Nervous and Mental Disorders. By David M. Olkon, S. B., A. M., M. D., Associate Professor of Psychiatry, College of Medicine, University of Illinois. Cloth. Pp. 310 with 138 engravings. Philadelphia: Lea & Febiger, 1945. Price $4.50.

The author dedicated this text book, which is written for students and physicians, to a rational understanding of psychiatry. In the introduction he deplores that the "new terms used in the description of mental abnormalities and behavior difficulties befog the problems." However, it is more confusing that the author uses old terms in an entirely different sense than the generally accepted one. For example, he defines "consciousness" as "The all embracing manifestation of behavior of the personality as a whole." Gastric secretion and muscular tension are for the author partial representatives of the total consciousness which is illustrated by the following example: "During deep sleep or deep anesthesia, respiration, heart beat and other vital processes are highly active, and at times even overactive, for instance when the anesthetic overstimulates respiration and heart action, yet the individual's awareness of these activities at such a moment is nil, and the processes of attention, recall, judgment, etc., are shut out of awareness by the anesthetic, or by the deep sleep."

The book touches on most subjects of psychiatry but the space allotted to different chapters is not related to the importance of the subject. Involutional melancholia is discussed on one-third of a page while Transvestism on six pages. The discussion of psychoneuroses, in fact the whole book, lacks an understanding dynamic psychologic approach to abnormal behavior. Some statements are baffling. For example, speaking of the manic depressive psychosis, the author says that suicide is encountered in the hilarious manic as readily as in the saddened uncontrolled depressive.

The experienced psychiatrist will find some interesting comments and views in this book, but it cannot give the medical student an adequate picture of present day psychiatry or serve him as a text book, nor can it be the source of information for the general practitioner. F. K.

The Story of Penicillin; Yellow Magic. By J. D. Ratcliff. With a foreword by Chester Keefer, M. D. Introduction by Morris Fishbein, M. D. Cloth. Pp. 173. With illustrations. New York: Randon House, 1945. Price $2.00.

This is a rapid-fire, fast moving success story—the story of penicillin, one of the most interesting achievements in modern medical science. It is primarily one of giving recognition first to those who were farsighted enough to recognize the potentialities which this drug possessed, secondly to the manufacturers who decided to cooperate in the stupendous task of production, then to those members of the medical profession who early gathered the important information as to the therapeutic possibilities, and later to the physicians both in civilian and armed services who by its use prevented many deaths.

The story will not only be of interest to those persons in medicine but should have a great appeal to the lay public as well. It would certainly furnish an hour's interest in light reading and yet unfold one of the most spectacular examples of collaborative efforts in our medical history. C. J. T.

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Trade News

Sterling-Winthrop Develops Method to Study Resistance of Bacteria to New Antibiotics

A method for studying the ability of bacteria to develop resistance to the action of such antibiotics as penicillin and streptomycin has been developed by scientists on the staff of the Sterling–Winthrop Research Institute. A report on this has just been published in the *Journal of Bacteriology* by John W. Klimek and Drs. Chester Cavallito and John Hays Bailey of the Institute staff.

These researchers believe that the "phenomenon of resistance" to antibiotics, which today limits the value to mankind of these new antiseptics, miracle workers though they are, may be involved in the mechanism by which the drugs act on the germs. Bacteria use up energy, to live and reproduce by burning up food materials with the help of catalysts which speed up and control the process. These catalysts are organized in what the scientist calls enzyme systems inside the bacterial cells.

It has been found that these enzyme systems may be attacked by antibiotics by having the sulfhydryl group in the enzyme molecule bound up so that the enzyme no longer can "catalyze" the chemical reactions. Antibiotics have been found to fall into two general classes, those which affect bacteria by binding their sulfhydryl groups very easily, and those which do so only under very special and restricted conditions.

The first group includes an antibiotic called gliotoxin, which has not yet been used medically, and the antibiotics from garlic and some burdock, a weed common over a large part of the country. The antibiotics which require special conditions for binding up the sulfhydryl groups are the better known ones such as penicillin, streptomycin and the new antibiotic from wild ginger.

It has been possible to create in the laboratory, models of groups in these enzymes which reveal by tests under simple laboratory conditions to which group a new antibiotic is apt to belong. Tests on these model enzyme groups show that the wild ginger, penicillin, and streptomycin antibiotics block the reactions in a way that resembles the effects on bacteria. At the same time it is these antibiotics to which bacteria may become so resistant that they are not killed by even one thousand times ordinarily fatal concentrations.

In contrast, bacteria do not seem to be able to develop increased resistance to those other antibiotics which fall in the first group of reacting with the sulfhydryl groups under almost all conditions. This matter of resistance is of considerable importance, since when patients are treated with too small doses of the antibiotic compound the bacteria are

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Feinberg, S. M.: Allergy in Practice, Chicago, The Year Book Publishers, Inc., 1944, p. 502.

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not completely killed and have time to develop a tolerance to the point where later larger doses may be found to be ineffective. In this way the beneficial therapeutic effect of the antibotic material may be in large part lost.

Stearns Steps Up Supplies of Gastron and Pepsencia

Gastron and Pepsencia, which have been in short supply because of difficulties in obtaining raw materials and because of increased demands by physicians, are gradually becoming more readily available, according to Dr. J. Mark Hiebert, vice-president and general manager, Frederick Stearns & Co. Division, Sterling Drug Inc. Doctor Hiebert also announces that by late fall of this year it is expected that Holadin and Holadin Bile Salts will be added to the list of former Fairchild Brothers and Foster preparations taken over by Stearns.

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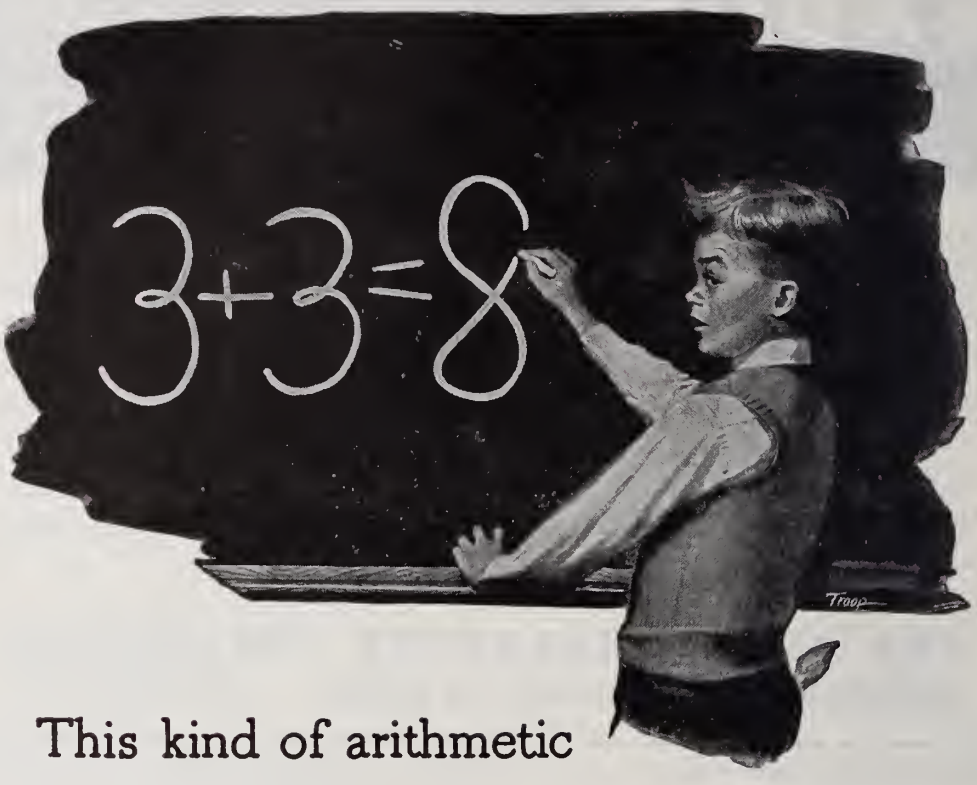

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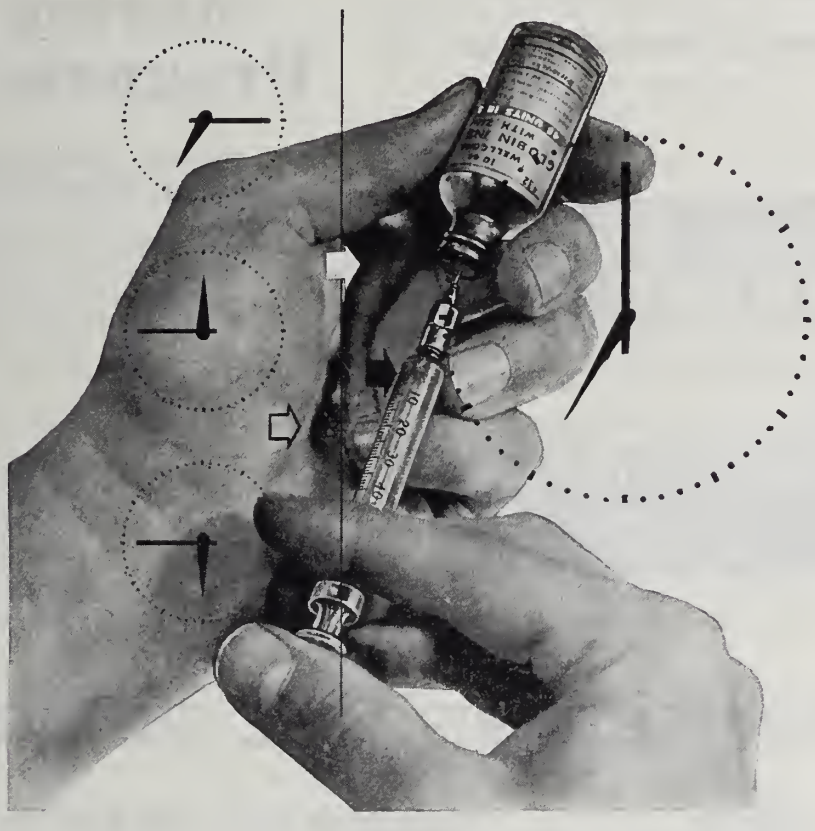

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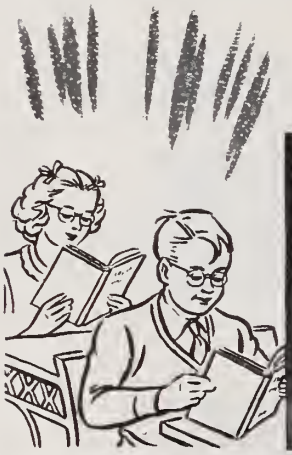

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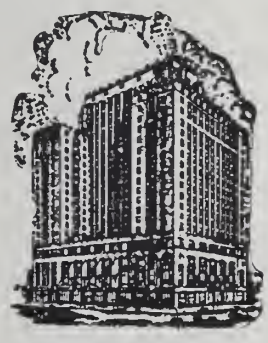

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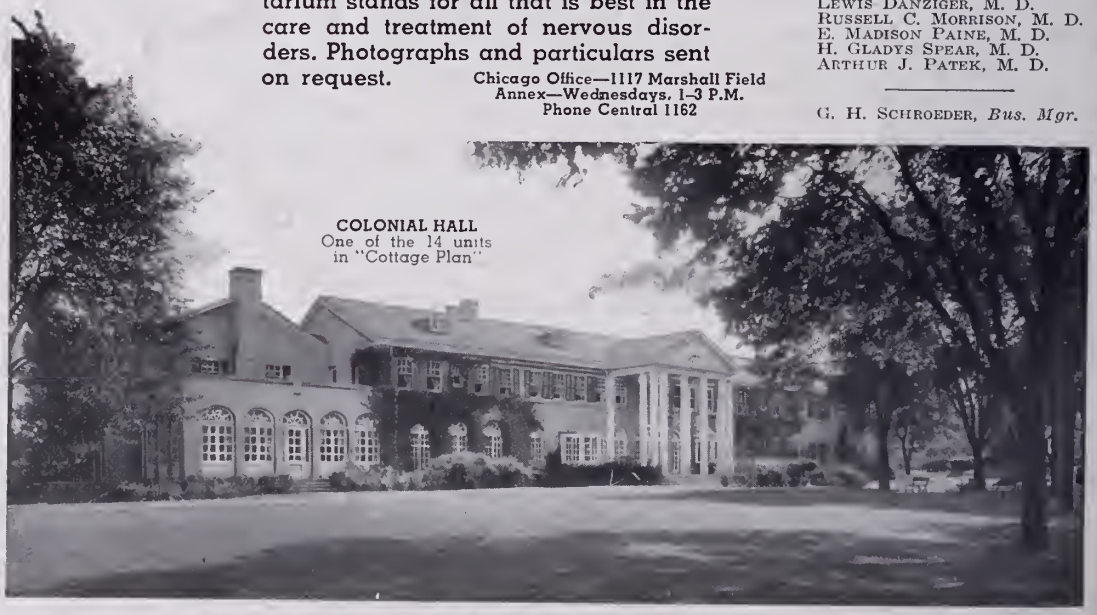

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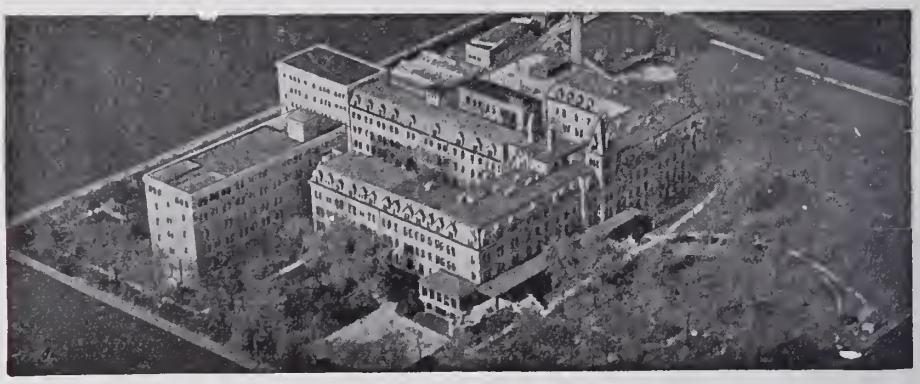

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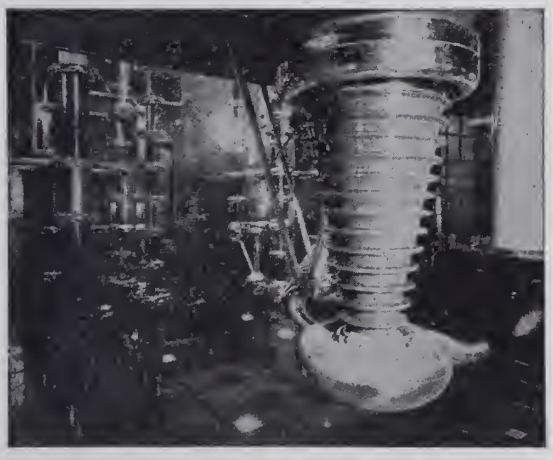

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1. Watson, B. P.: J. Clin. Endocrinology 4:571 (Dec.) 1944.

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Shambaugh, G. E., Jr.: J. Iowa M. Soc. 31:373.

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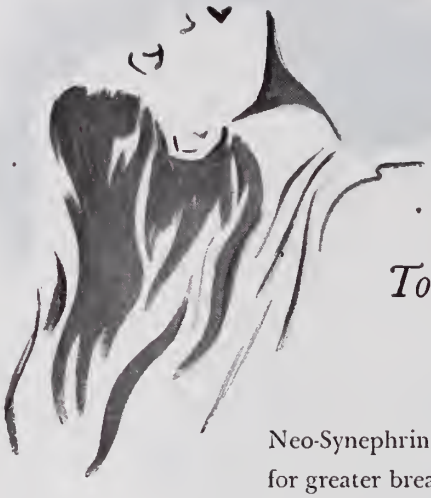

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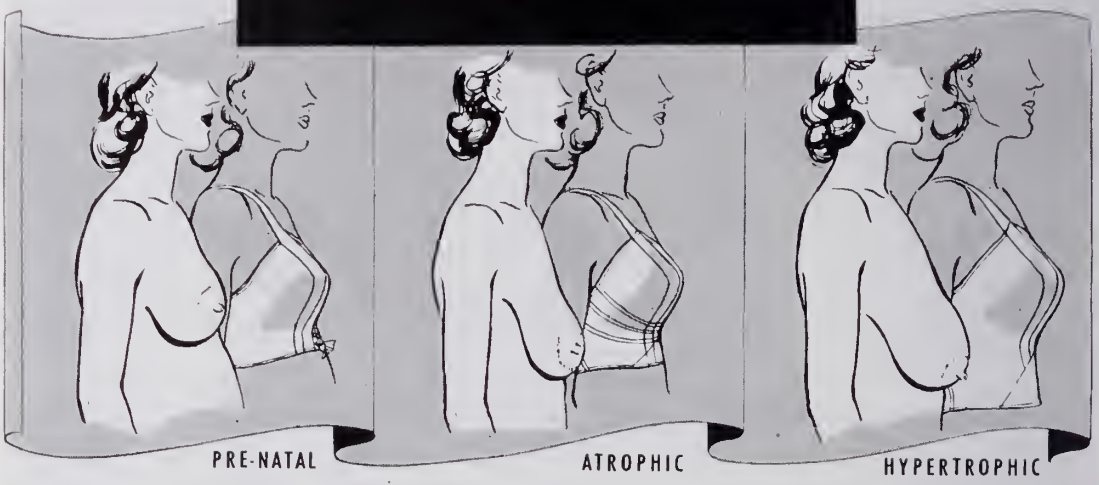

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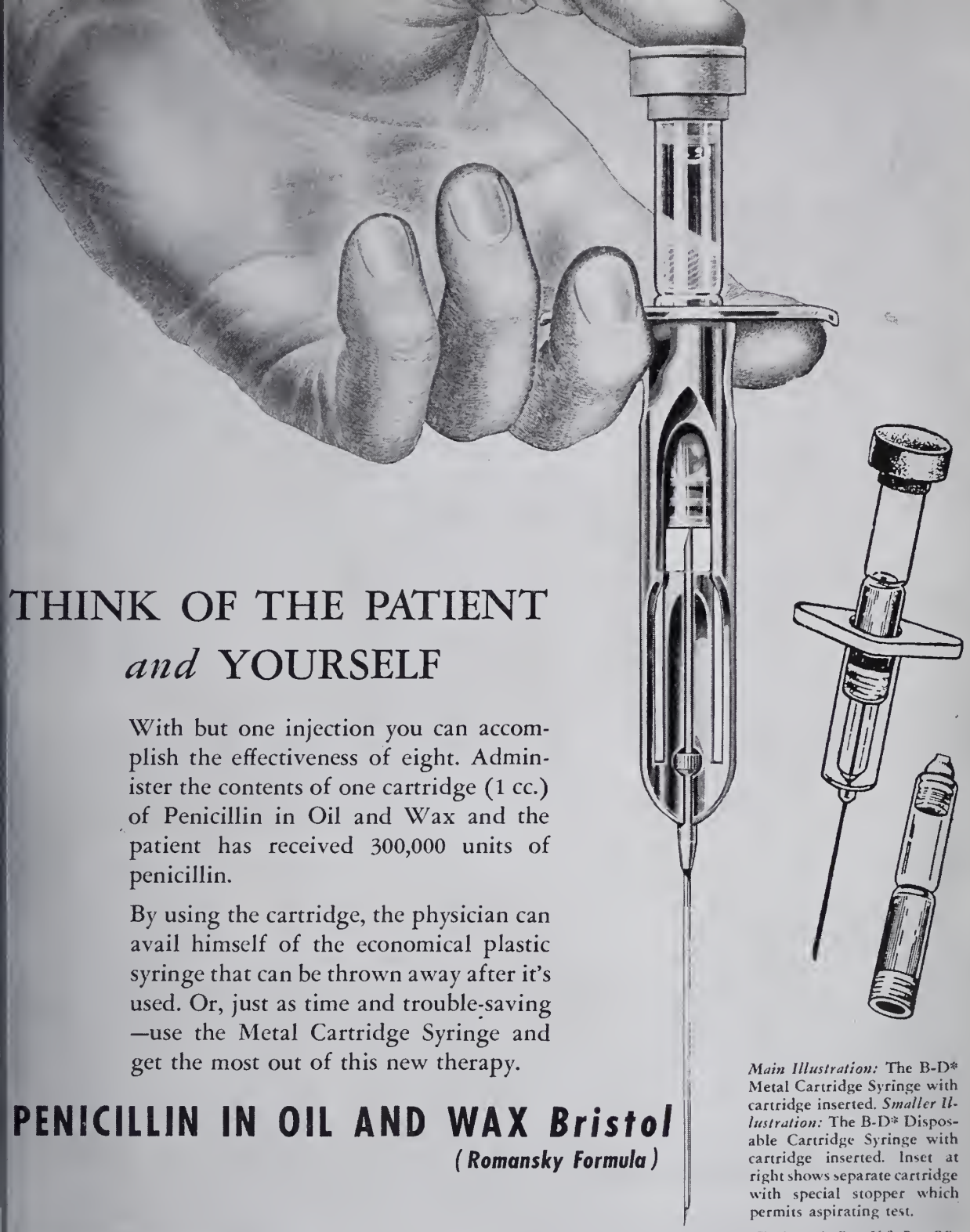

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1. Dannenberg, M.: Am. J. Roentgenol. 51:328, 1944.

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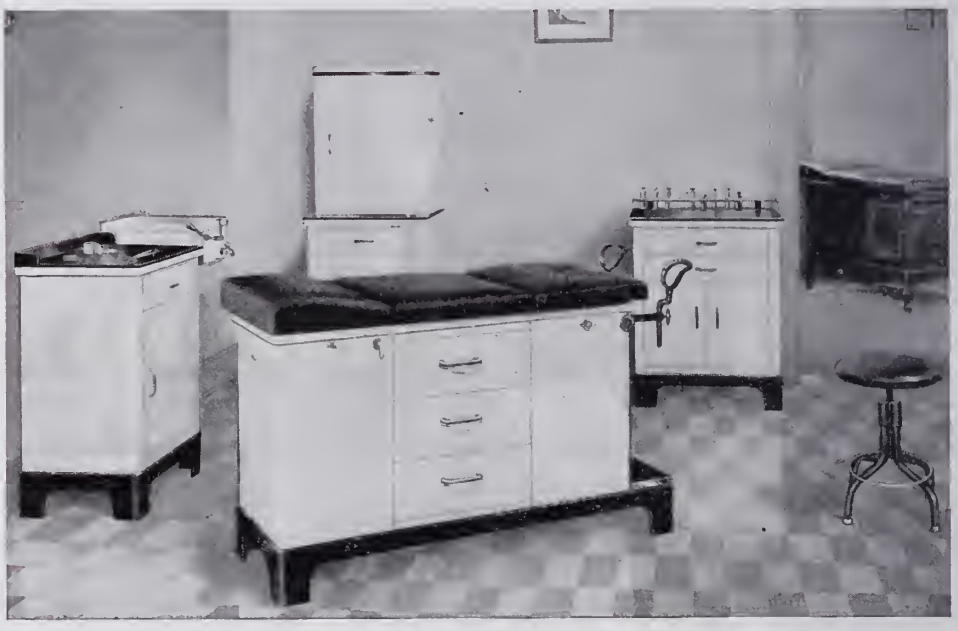

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**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154.*
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60.

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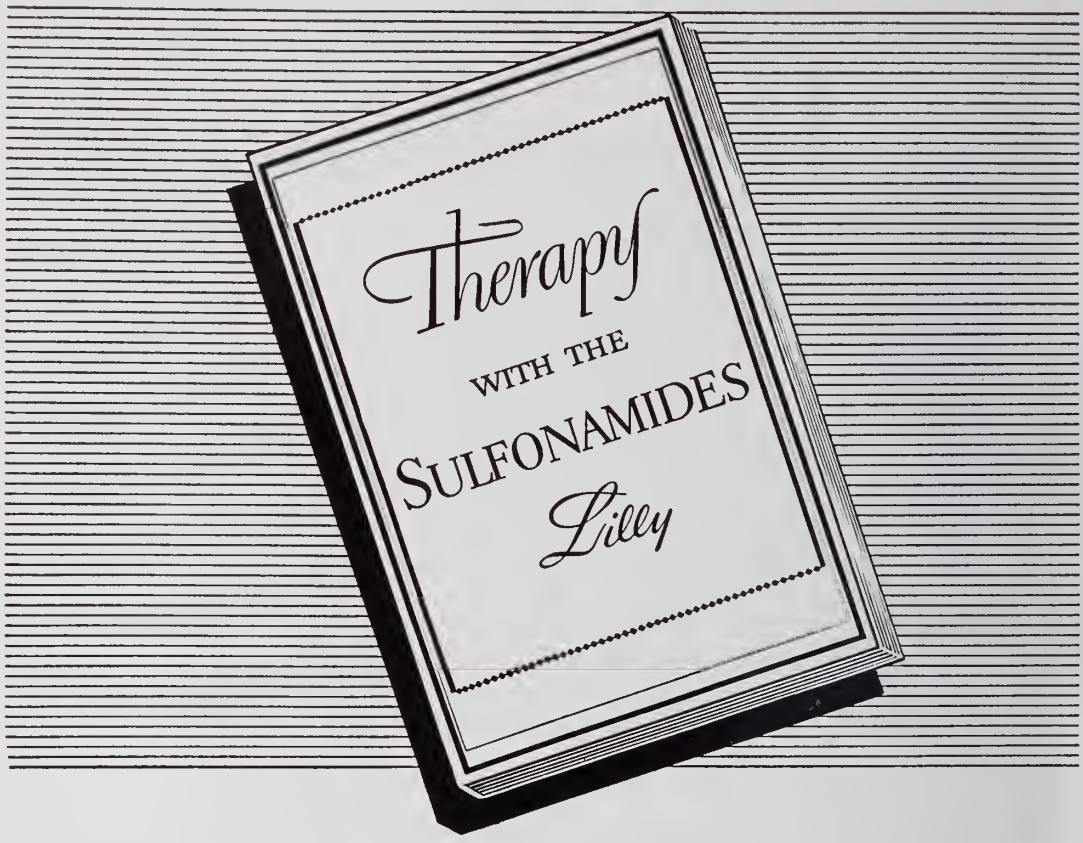

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THE WISCONSIN MEDICAL JOURNAL

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"Relapsing" and "Recurring" Meningitis*

By MAX J. FOX, M. D.
Milwaukee

M. J. FOX

Medical director of Southview Hospital and associate clinical professor of medicine at Marquette University School of Medicine, Doctor Fox has been certified by the American Board of Internal Medicine. He was graduated from Marquette University School of Medicine in 1923, and is a Fellow of the A. M. A.

SOMETIMES patients who have suffered an attack of meningitis and are discharged as apparently recovered appear at a later date with a return of the signs and symptoms of meningeal infection. Such cases have been reported by Schaffer and Freeman,[1] Corfield,[2] Worster–Drought and Kennedy,[3] Weinstein, Louis and Stanley,[4] Herrick and Dannenberg,[5] and Christie.[6] In most of these cases the signs and symptoms reappeared during the convalescent period. These, in our opinion, should be designated as cases of "relapsing" meningitis. Much less frequently a patient recovers completely from the original infection and engages in normal activity for a variable period of time before the return episode of the disease. Such cases we designate as "recurring" meningitis.

The purpose of this report is to present two cases which illustrate the distinction between relapsing and recurring meningitis and to offer suggestions as to the possible causes of each.

REPORT OF CASES

Relapsing Meningitis

Case 1.—J. S., a 65 year old white man, entered South View Hospital March 23, 1943, with the chief complaint of severe frontal headache which developed two days before admission. Two days before the onset of the headache he developed an acute infection of the upper part of the respiratory tract accompanied by fever, projectile vomiting, neck stiffness, difficulty in walking, and ptosis of the left eyelid.

Physical examination revealed hyperactivity of the superficial and deep reflexes. The Kernig and Babinski signs were present. The levator palpebrum was paralyzed. The heart and lungs were normal. There were no skin manifestations. The temperature was 98.2 F., the pulse 88 per minute and the respiratory rate 24 per minute.

The cerebrospinal fluid on admission contained 11,963 cells per cubic millimeter and gram-positive diplococci which resembled pneumococci. The quellung test with type 29 antiserum was positive. Spinal fluid glucose was 11 mg. per cent and total protein was 600 mg. per cent. On the day following admission the blood leukocyte count was 5,800 and the hemoglobin 70 per cent. The urine had a specific gravity of 1.015, was alkaline in reaction, and contained a trace of albumin. The microscopic examination of the urine showed a few casts, cocci, and yeast cells. Four days after admission the urine was normal.

The patient was placed on a sulfadiazine regime with light diet and fluids as desired.

Nine days after admission examination showed ptosis of the left eyelid and a slight deviation of the left eye on converging. The temperature was 98.6 F., the pulse rate 72, and the respiratory rate 18.

On April 5, thirteen days after admission, the patient was discharged, subjectively and objectively well.

Six days after discharge the patient was readmitted to the hospital. He was in deep coma and exhibited marked opisthotonus, clamping of the jaws, and rigidity of all body muscles. The Kernig and Brudzinski signs were present. The superficial and deep reflexes were hyperactive and the Babinski, Oppenheim, and Gordon signs were positive. Bilateral nystagmus was noted. Petechiae were distributed over the entire body. The heart sounds were weak but the lungs were normal. The patient was markedly cyanotic. The temperature was 103.6 F., pulse rate 112 per minute, and the respiratory rate 26 per minute.

At this time the spinal fluid was grossly milky and blood-tinged. Microscopically it contained mostly polymorphonuclear leukocytes and gram-positive diplococci which gave a positive quellung reaction

* From South View Isolation Hospital of the Milwaukee Health Department and the Department of Internal Medicine, Marquette University School of Medicine.

with type 29 antiserum. The spinal fluid glucose content was 10 mg. per cent, total protein was 286 mg. per cent and the sodium chloride was 679 mg. per cent. On the following day gram-positive diplococci resembling pneumococci were cultured. The blood leukocyte count was 21,650 per cubic millimeter and the hemoglobin was 85 per cent.

Sulfadiazine medication was immediately resumed. Three days after his readmission the patient was transferred to St. Mary's Hospital. At this time the blood leukocyte count was 12,300 per cubic millimeter. The urine had a specific gravity of 1.018, was alkaline in reaction, and contained traces of albumin and sugar.

Recurrent Meningitis

Case 2.—K. T., a 30 year old white woman, was admitted to South View Hospital November 7, 1945, complaining of headache, chills, fever, and stiffness of the neck. The reflexes were hyperactive and the Brudzinski and Kernig signs were present. There were no petechiae. The temperature was 103 F., the pulse rate 135 per minute, and the respiratory rate 35 per minute.

The spinal fluid was under slightly increased pressure, milky, and contained 24,830 cells per cubic millimeter of which 95 per cent were polymorphonuclear leukocytes. Gram-negative intracellular and extracellular diplococci which resembled meningococci were found in the spinal fluid. The blood leukocyte count was 22,000 cells per cubic millimeter. The urine was normal.

An intensive course of combined penicillin and sulfadiazine therapy was instituted. Recovery was prompt and convalescence, uneventful. The patient was released after eleven days in the hospital.

The patient stated that she felt very well on returning home and that she gained weight. On January 24, 1946, seventy-nine days after her release from the hospital, a number of scattered petechiae suddenly appeared on her skin. These persisted for two days and then slowly faded. There were no further indications of meningeal infection. One hundred twenty-two days after discharge from the hospital and forty-three days after the petechiae appeared, the patient developed a rash which lasted for three days. This was followed by the rapid development of a severe and pounding headache, stiff neck, and blurred vision.

The patient was readmitted to the hospital. Physical examination revealed a moderately cachectic white woman with petechiae scattered over the trunk and extremities. There was no stiffness of the neck and the reflexes were normal.

The spinal fluid was under normal pressure, cloudy, and contained 12,700 cells per cubic millimeter of which 90 per cent were polymorphonuclear leukocytes. Intracellular and extracellular gram-negative diplococci were again found in the spinal fluid. A blood culture taken on admission was positive for meningococci.

The patient was again placed on an intensive combined penicillin and sulfadiazine regime with prompt and favorable result.

Discussion

Relapsing meningitis is thus a repetition of the disease syndrome occurring during the convalescent period of the disease. Presumably the relapse is dependent on persistent infection which is not necessarily demonstrable by clinical symptomatology or laboratory tests. Before the advent of chemotherapy relapses occurred in about 50 per cent of the cases of meningitis. With the use of the sulfonamides relapses have been reduced to 8 per cent.[4] In our experience some or all of the cardinal signs and symptoms of the infection may reappear when chemotherapy is discontinued immediately after recovery from the acute phase of the disease. For this reason we strongly emphasize the necessity for continuing the therapy until convalescence has been well established and normal activity resumed.[7]

Recurring meningitis is a repetition of the disease syndrome occurring after convalescence and often after the patient has resumed his normal activities. Such a recurrence may result from: (a) continued contact with the original source of the infection, (b) carriers, (c) contact with a different antigen, and (d) persistent foci within the body. In the case presented here it is possible that the recurrence resulted from persistent infection within the body as evidenced by the petechiae which appeared forty-three days before the onset of the recurrence of the disease. That exogenous reinfection is also possible is demonstrated by the case of Corfield[2] in which successive attacks were caused by different organisms.

Summary

1. Relapsing and recurring meningitis are defined.
2. A case of relapsing pneumococcic meningitis is presented.
3. A case of recurring meningococcic meningitis is presented.
4. The mechanism of relapse and recurrence are discussed.

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A Case of Morton's Metatarsalgia (Morton's Toe) Treated by Operation

By J. O. DIETERLE, M. D. and J. F. KUZMA, M. D.
Milwaukee

J. O. DIETERLE

A 1916 graduate of the University of Michigan Medical School, Ann Arbor, Mich., Doctor Dieterle has practiced in Milwaukee since 1920, specializing in orthopedic surgery. He is a member of the American Board of Orthopedic Surgery and a number of other national and local medical societies.

J. F. KUZMA

Doctor Kuzma, a 1939 graduate of the University of Illinois, is a member of the faculty of Marquette University School of Medicine, Departments of Bacteriology and Pathology: Acting Director of Laboratories, Milwaukee County Hospital; and Director of Laboratory, Milwaukee Hospital.

MORTON'S neuralgia or Morton's toe is a painful condition in the metatarsus characterized by paroxysms or spasms of pain in the neighborhood of the fourth metatarsophalangeal joint. The majority of the cases occur in women of middle or past middle age. In a typical case the patient suddenly experiences a burning pain, sometimes accompanied by a slipping sensation, at the base of the fourth toe. To get relief the shoe is removed and the forefoot massaged until the seizure passes. These symptoms are repeated at varying intervals until the patient may become quite disabled.

In December 1941, Dr. R. T. McElvenny of Chicago presented a paper at the Chicago Surgical Society on the etiology and surgical treatment of so-called Morton's metatarsalgia or Morton's toe. Dr. L. O. Betts of Australia reported 25 cases stating that he treated the condition surgically for the first time in 1931. Prior to this work the causative factor in this condition was not recognized and the treatment consisted of the application of inserts in the shoes or attachments on the sole of the shoe. In some cases relief was so obtained but in others the pain was intractable and most orthopedists advocated resection of the head of the fourth metatarsal bone as a last resort. The conclusions of Doctors McElvenny and Betts, reached independently, were that in those cases where the pain in the metatarsus is persistent, severe, and unrelieved by shoe alterations, the cause is neuroma or neurofibroma formation in the lateral branch of the median plantar nerve just distal to the interspace between the third and fourth metatarsal heads. Surgical removal of the neuromatous tissue cures the condition.

The case here reported is in a woman 54 years of age. She complained of persistent pain for three years in the left forefoot which could not be relieved by shoe alterations, plantar pads, or other treatment. On examination she invariably localized her pain in the web between the third and fourth toes. There was no mass to be palpated. On occasions she also complained of pain between the second and third toes.

The following operation was done in April 1946.

Under sodium pentothol anesthesia the left leg was elevated and exsanguinated by elastic bandage followed by application of tourniquet. Straight web-splitting incisions were made between the second and third and between the third and fourth toes. Nothing was found between the second and third toes but in the interval between the third and fourth toes there was found a diffuse mass of glistening whitish tissue. This tissue was excised and grossly sectioned but nothing typical in appearance was recognized.

The patient made an uneventful recovery and reports that her pain has disappeared since the operation.

The laboratory report by Dr. J. F. Kuzma follows:

Gross: Specimen is a pale rather soft pliable fragment of fibro-fatty substance measuring 20 mm. by 10 mm. by 8 mm. It contains a number of pale string-like bundles.

Microscopic: The submitted tissue is composed of a mixture of cellular and hyalinized connective tissue in which are embedded thick-walled arteriolar branches and a number of nerve bundles. The vessels generally show subintimal fibrosis which in certain instances is so marked as to have produced complete obliteration of the lumen. Externally the vessels are accompanied by thick hyalinized connec-

tive tissue. The nerve bundles present show a change which is similarly characterized by formation of perineural connective tissue of broad hyalinized laminations. From these peripheral areas of fibrosis there are extensions of rather thin wavy collagenous fibers that distort the pattern of the nerve bundle (fig. 1). Special stains show distinct degenerative processes of the nerve fibers. The entire complex of connective tissue involvement of the nerve bundles and subintimal fibrosis producing endarteritis can reasonably be interpreted as a reaction to trauma.

Microscopic Diagnosis: Neuroma.

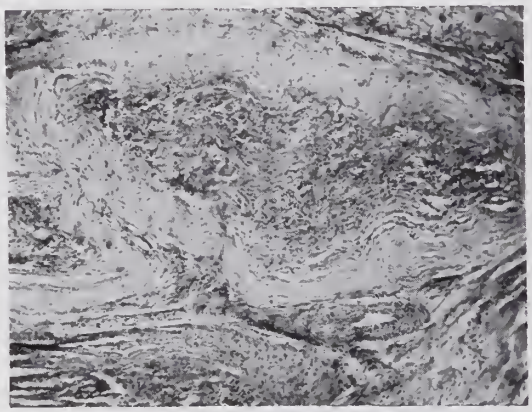

Fig. 1.—Photomicrograph of the interdigital neuroma. Note the oval form of wavy collagenous fibers surrounding the disorganized and scarred nerve bundle.

Comments

In doing the operation general anesthesia is preferred to local as there is no distortion of tissue. Exsanguination of the leg will help also to more easily recognize the neuromatous tissue. In patients where the complaint of pain is in other locations than between the third and fourth toes it might be well to make additional incisions. This case confirms what McElvenny stated in his report—that the pathology of the condition is a neuromatous or neurofibromatous formation almost invariably found in the interval between the third and fourth toes.

REFERENCE

McElvenny, R. T.: Etiology and surgical treatment of intractable pain about fourth metatarsophalangeal joint (Morton's Toe), J. Bone & Joint Surg. 25:675–679 (July) 1943.

SEVENTH ANNUAL DEARHOLT DAY

TENTATIVE PROGRAM

Presented for the medical students and the general medical profession of Wisconsin by the Wisconsin Anti-Tuberculosis Association

Cooperating with the WATA are the:

Marquette University School of Medicine
University of Wisconsin Medical School
Milwaukee Academy of Medicine
Dane County Medical Society
Wisconsin Trudeau Society

PROGRAM

Madison, Monday, November 18, 1946

p.m.
3:00—Auditorium, Service Memorial Institute, University of Wisconsin, North Charter Street.

Presiding—Introductory Remarks: Dr. William S. Middleton, dean, University of Wisconsin Medical School, Madison.

"B. C. G. in Tuberculosis"—Sol R. Rosenthal, Major M. C., chief of laboratory service, Bruns General Hospital, Santa Fe, New Mexico.

"The Cause of Apical Localization of Tuberculosis and its Implications for Treatment"—Dr. Julius L. Wilson, associate professor of medicine, Tulane University, New Orleans, Louisiana.

p.m.
8:15—Meeting of the Dane County Medical Society, Wisconsin Trudeau Society, and guests, Hotel Loraine.

Presiding—Introductory Remarks: President, Dane County Medical Society.

"B. C. G. in Tuberculosis"—Doctor Rosenthal.

"Pulmonary Emphysema: Pathologic Physiology and Treatment"—Doctor Wilson.

(Continued on page 996)

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Suppurative Lung Abscess

During the past ten years the mortality rate of suppurative lung abscess has been reduced dramatically from 50 to 5 per cent. More important, the prolonged morbidity, often associated with irreversible changes in the organs by amyloid degeneration, is now rarely seen. These improvements are due to a better understanding of the etiologic factors and pathologic changes, the newer chemotherapeutic agents, and the recent advances in thoracic surgery.

Bacteria can enter the lung by way of four routes: 1. Aspiration (pus from oropharyngeal infection, gastric contents during or immediately after anesthesia, such foreign bodies as peanuts,) 2. blood stream (embolic phenomena associated with furunculosis or gangrenous meso-appendix,) 3. lymphatics spread (seen with subphrenic abscess,) 4. direct extension by a penetrating wound. Cystic disease secondarily infected does not fall into any of these groups, but for all practical purposes it can be considered a lung abscess. The bacteria by themselves are incapable of producing an abscess, for nature would expel them quickly by its defense mechanism of mucous formation and coughing. There must therefore be a second factor —bronchial obstruction—which may or may not be temporary.

Treatment is dependent upon 1. removal of inciting cause, 2. adequate drainage of the abscess, and 3. the use of chemotherapy. If early in the acute phase proper conservative measures are instituted, over 50 per cent of the abscesses will heal. Foreign bodies if present must be removed by bronchoscopy. Adequate and complete drainage of the abscess by regular, periodic, postural drainage must be carried out. As with abscesses elsewhere in the body, repair cannot take place in the presence of pus. The patient is advised to place his HIPS at the edge of the bed (not his chest) and rest the head on the floor or low stool. This procedure is performed six times daily, initially doing it for two minutes but progressively and gradually increasing to fifteen minutes. Occasionally bronchoscopy may aid in initiating expectoration.

Ideally the pulmonary secretion should be studied for type of organism and its sensitivity to penicillin and sulfonamides. Penicillin is employed either intramuscularly, 30,000 units every three hours, or given in the form of aerosol inhalations. The first dose of sulfadiazine is 2 Gm., and 1 Gm. every four hours is given thereafter. The trivalent arsenicals, such as mapharsen, are of value only in those abscesses containing fusospirochetal organisms. Supportive treatment of absolute bed rest, forcing fluids, high vitamin and high caloric diet should not be denied these patients.

If the patient responds by demonstrating adequate drainage and reduction in size of the abscess, then conservative therapy is continued. If, on the other hand, at the end of two weeks there is inadequate drainage or no decrease in size of the cavity, surgery is indicated.

The surgical procedures utilized in the treatment of lung abscess are 1. cavitary drainage (thoracotomy,) and 2. pulmonary resection. Cavitary drainage is desirable in single abscesses situated close to the chest wall. Fortunately, most abscesses fall in this category. Pulmonary resection is indicated in single abscesses situated in the mid lung field, in the presence of multiple abscesses, or in cystic disease secondarily infected. In the latter group of cases resection is required because of inadequate drainage of the multiple abscesses, or because of the danger of extensive hemorrhage in cauterizing through considerable lung tissue, or because a cystic wall would prevent closure of the cavity by fibrosis.

In lung abscesses of long standing in which roentgenograms reveal a thick wall, healing by contraction and fibrosis is improbable and surgery is therefore generally required.
—A. R. Curreri, M. D.

The Relation of the Medical Staff to the Hospital

By WARREN P. MORRILL, M. D.
Chicago

W. P. MORRILL

Doctor Morrill, director of research of the American Hospital Association, Chicago, is a 1908 graduate of Johns Hopkins University School of Medicine. The doctor, a veteran of World War I, has served as superintendent of hospitals in Baltimore; Winnipeg, Manitoba, Canada; Augusta, Ga.; Shreveport, La.; and Washington, D. C.; as a private practitioner in Benton Harbor, Mich.; and as field representative of the American College of Surgeons.

ANY consideration of the relation of the medical staff to the hospital must be based on an understanding of the legal status of both.

From a legal standpoint there are three types of control of hospitals. The first, the smallest, and the rapidly declining group, is the so-called proprietary hospital. This type is owned and operated by an individual, a partnership, or a corporation, and being a purely private enterprise the owners and operators have the same control of organization and operation as do the owners of any other private commercial enterprise.

The second type is the so-called governmental hospital in which the tax-spending agency, be it Federal, state or local, in the exercise of its general police powers and obligations, establishes and operates the hospital. In its pure form this type is the public charity hospital that does not take patients who are able to pay even part of the cost of their care. Actually this type of hospital is not common except in the larger communities. In many smaller communities, a hospital may be built with funds supplied by a tax-spending agency, but operation may be directed either by the tax-spending agency or by some other agency, either indirectly or remotely operated and controlled by the tax-spending agency, or turned over to an entirely independent agency for operation. In this variant it is customary to accept pay as well as non-pay patients.

The third and most common type is the so-called voluntary hospital, owned and controlled by a non-profit private corporation. Its original capital funds come to it as voluntary donations; any deficits resulting from operation are usually made up from similar sources; any profits it may make can not be distributed, either directly or indirectly to any officer or member of the corporation.

It is only in respect to the governmental and voluntary types of hospitals that the right of the governing board to appoint the medical staff and to make rules and regulations for their control has been challenged in the courts. The earlier court cases involved the attempts of osteopaths to force their acceptance on the hospital staff. Later cases involved physicians, and the more recent ones involved physicians upon whom governing boards of hospitals had imposed limitations as to the types of cases they might be permitted to treat. In the cases against tax-supported hospitals the plea has usually been based on the claim that the applicant as a taxpayer could not be denied the use of tax-supported facilities. In other cases the plea has been that being licensed by the state to practice the "art of healing," the denial of hospital privileges interfered with their right to earn a livelihood by the practice of their profession.

The outcome of all cases which have reached either the Federal or state supreme or appellate courts has been the same. These courts have invariably upheld the right and obligation of the governing board to exercise "due care and diligence" in opening the facilities of the hospital to use by physicians and to "make reasonable rules and regulations for their control."

These decisions have been based on the principle that the hospital is established and operated for the welfare of the community and not for the convenience or profit of the physician; that the governing board "as owners" is responsible not alone for the property and finances of the hospital, but for the quality of its service to the community as well; and that for the court to deny the governing board the right to appoint and control the medical staff would absolve the governing board from its obligation to provide proper service to the community.

The obligation of the governing board to exercise "due care and diligence" in the selection of the staff and to "make reasonable rules and regulations for their control" at once raises the question of the competence of a board consisting largely, if not exclusively, of laymen to discharge this duty.

In some instances this problem has been met by appointing physicians to membership on the governing board. In the opinion of experienced and qualified observers this is not a satisfactory procedure. The physician board member, however well qualified either professionally or temperamentally, is not responsible to the staff, and in any case represents only his own opinion. If a member of the staff, he is likewise placed in the invidious position of alone judging not only his own performance but that of other members of the staff. It is not reasonable to expect him to be entirely fair, both to himself and to his professional conferees.

The more successful procedure involves the formal organization of the staff into a working administrative unit to which the governing board can turn for advice on such professional matters as come before it. Ordinarily this takes the form of an organization of the staff as a whole and the selection of a small committee to do the detail work involved in such advisory service. This committee may either be elected by the staff or selected by the governing board. Since the governing board is to depend upon this committee as its medical advisory board for guidance in professional matters, it is necessary that it be composed of men in whose judgment the governing board has full confidence. Also, since it must represent the staff, it is well to include one or more members elected by and responsible to the staff itself.

The problem of organization of the staff in the community of 50,000 or more is not as difficult as in a smaller one. In this larger community it is customary to organize the staff in two sections—an attending or active staff, and a visiting or courtesy staff. The active staff will in general be composed of those physicians who are qualified and limit their work more or less closely to a specialty, who are the most regular and consistent in their use of the hospital, and who thus have the most definite interest in its proper functioning as an integrated health agency. The courtesy staff, on the other hand, will be composed of general practitioners and of those specialists who use the hospital less regularly and who have less interest in its operation as an organized unit.

The active staff is organized by specialty groups such as internal medicine, surgery, obstetrics, and head specialties. The numbers of such specialty divisions will usually be determined by the size of the hospital, and the number and professional and personal caliber of the men available to staff each such division. Within the division each member should be given definite seniority status such as chief, senior attendng, junior attending, and assistant or associate. The men in the lower levels will in general be the younger men who perhaps do not limit their work to their chosen specialty but are regarded as likely prospects for elevation to the higher positions as vacancies occur and as the juniors demonstrate their fitness for promotion. Recently it has been suggested that, in order to make the junior positions more attractive, the tenure of each grade be limited, and that when a man becomes eligible to promotion by years of service but who has failed to measure up to adequate standards for the next higher position, he be transferred to the courtesy staff and thus taken out of the line of promotion to make way for a candidate younger in the service but better fitted for promotion. Since every member of the active staff should be regarded as a potential future chief of service, not only his professional attainments but his personal traits and the respect in which he is held by his confreres should enter into consideration of his qualifications for promotion.

In some instances it has been found both desirable and workable to set up a general practice division of the active staff on the same status as that of the specialty divisions.

The courtesy staff consists of those physicians of the community who desire to use the facilities of the hospital but who either are not qualified for appointment to any specialty staff or are not sufficiently interested in the administration of the hospital to assume the obligations that are necessary to membership on the active staff.

Appointments

In all cases, original appointment to the staff should be based on a formal written application which, in addition to personal data, should include a statement of medical education, postgraduate and special training, the branch of medicine the applicant proposes to practice in the hospital, and a pledge that if appointed the applicant will abide by such rules and regulations as the governing board may make for the control of professional service within the hospital. On the basis of this application and with the recommendation of its medical advisory board, the governing board is enabled to fulfil its legal obligation to "exercise due care and diligence" in the appointment of members of the staff.

This will, of course, include such limitations as the governing board may impose as to the branches of medicine each appointee may practice in the hospital. Normally these limitations will be such as are recommended by the medical advisory board.

All appointments should be made for one year only but renewable at the discretion of the governing board without reapplication.

This method of making appointments has been criticised as discriminatory but it is necessary that in the exercise of due care and diligence the governing board must discriminate between the ethical and capable applicant and the inethical, the incapable, and the cultist.

In order to fulfil its function as the professional advisory body to the governing board, the staff should organize itself as a formal administrative body. It should elect a chairman and secretary and appoint such committees as are necessary. Since so large a body may not function well from an administrative standpoint it is well to have at least three committees: an executive committee, a records committee, and a program committee.

The executive committee as the name implies will formulate proposals for the action of the staff as a whole and will normally represent the staff in all dealings with the governing board. In hospitals having large staffs it is logical, but not obligatory, that the chiefs of services and the chairman of the staff comprise this committee since presumably each chief of a service can adequately represent the interests of his service, while the chairman of the staff represents the interests of the staff as a whole.

With the organization of the staff executive committee, including the chairman of the staff and the chiefs of service, the governing board will usually be glad to constitute this committee as its medical advisory board and thus effect a close liaison between the board and the staff.

The functions of the record committee and the program committee as the names imply, are the critical supervision and evaluation of the medical records and the preparation of the program for the monthly staff conference.

The Small Hospital

The hospital of less than 100 beds may be serving a community too small to permit representation of all the major specialties by separate divisions of the staff. In such a case the organization can not of course be as definite and clear cut as outlined for the larger hospital, but the general principles of staff responsibility still can be preserved. Thus the services may be limited to a medical, a surgical, and possibly a head specialities service or a general practice service. This will at least give a definite organization and provide a means by which the staff can be formally represented in its dealings with the governing board. The governing board may prefer to chose its own medical advisory board particularly when the staff is reluctant or dilatory in perfecting its own organization. It is not possible for all members of the staff to be chiefs of services or chairman, but in effect they must be willing to set up some form of formal organization or to content themselves with no one of their own choosing to represent them in dealing with the board.

Medical Records

Sir William Osler was fond of quoting Sir Francis Bacon: "Reading maketh the full man, conference the ready man and writing the exact man." The necessity for keeping medical records is not alone in their value as a record but even more in their influence in forcing the physician to more accurate thinking and thus to better care of the immediate patient. The excuse of the doctor that he does not have time to write a clinical record thus becomes in effect a confession that he does not have time to give the case the careful consideration to which the patient is entitled.

This does not mean that the volume of a clinical history is any index of its value. It has been said that words were invented to conceal thought and voluminous clinical records sometimes exemplify this thought. Actually there are but a few elements necessary to constitute a good history. Do the history and examinations, both physical and laboratory, justify the diagnosis? Does the diagnosis justify the treatment? Do the progress notes give a clear picture of the patient's progress? Do the diagnosis and the progress notes justify the outcome?

Any notations in the history beyond these requirements may serve to obscure rather than to clarify the record.

Two other items that are of importance are the pathologic tissue and necropsy reports and the consultation records. The Council on Medical Education and Hospitals of the American Medical Association considers necropsies of such importance that it requires a fixed percentage of necropsies for a hospital to qualify for the training of interns. Of similar significance is the requirement of the American College of Surgeons that all tissue removed at operation be submitted for pathologic diagnosis and that this report be incorporated in the patient's history. Another item that every experienced investigator takes into consideration is the consultation record. Thus, an unsatisfactory outcome of a case with no record of a consultation places the attending physician on the defensive. Just as these items are taken into account in judging the performance of the hospital as a whole, so they may be taken into account in judging the professional performance of individual physicians.

It is so simple for the physician, or more particularly the surgeon, to avoid the more desperate cases that the mortality rate is not a fair index of performance. But a record of adequate laboratory examinations, of adequate consultations, and a fair percentage of autopsies at least shows careful procedure and an earnest effort on the part of the physician or surgeon to profit by his mistakes.

The hospital is every day more and more proving itself the place for the sick to bear their illness more comfortably and to recover more certainly and more quickly. This is not alone due to the advances of medical science, but rather that the hospital and its organized staff offer all the facilities, both physical and professional, that are needed to apply these improvements in our medical knowledge.

The physician who does not offer these advantages to his patient to the greatest possible extent is not doing his full duty to his patient.

TUBERCULOSIS POSITIONS AVAILABLE

Dr. Delmar Goode, branch medical director, has stressed the urgent need for physicians interested in tuberculosis and tuberculosis specialists in the Veterans Administration. This is particularly true of the veteran's hospitals in Wisconsin, Indiana, and Illinois.

Numerous positions are immediately available with salaries ranging up to $11,000 per annum, depending upon training and experience. There are opportunities for postgraduate work and individual research.

Applications may be obtained by addressing Dr. Delmar Goode, Branch Medical Director, Veterans Administration Branch Office #7, 226 West Jackson Boulevard, Chicago 6, Illinois.

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« « « EDITORIAL » » »

On the Air

THE cooperation which the Society has received from the radio stations in this state is so outstanding that it deserves editorial mention. At the present time eighteen stations in Wisconsin and five in Michigan, two of which also serve Wisconsin audiences, are broadcasting the Society's health series, *The March of Medicine.* Twenty-two of the twenty-three devote fifteen minutes each week without charge for this purpose; the other one is currently alternating a Society program with one supplied by the Anti-Tuberculosis Association. The schedule for each station appears in the Medical Forum of this issue.

These radio stations are besieged with requests for free time by dozens of agencies, so they do not broadcast the Society's series for lack of material. In fact, in many instances, other programs have been pushed aside to accommodate them.

While it speaks well for the series, it speaks better for the radio stations. In the twenty-five years of radio, the power and prestige of that means of communication has grown to the point where it is the most effective instrument of public information. As women pursue their household tasks and traveling men drive through the country, they listen and learn. Through no other channel, except personal contact, can one learn while engaged in other tasks.

The public is fortunate that the officials of most radio stations have seen fit to use this forceful implement for beneficial purposes. The State Medical Society is grateful that they have seen fit to make this contribution toward the advancement of better health in Wisconsin.

Notes on Clinical Pathology

Editors—WALTER H. JAESCHKE, M. D., University of Wisconsin, Madison, and
S. B. PESSIN, M. D., Marquette University, Milwaukee

The Differential Count Says

Everyone has had an unfortunate experience of basing a diagnosis on the white blood cell count. Too often normal daily variations and paroxysmal episodes of leukocytosis (such as after meals, exercise, fright, pain, afternoon counts,) add to the difficulty of interpretation; therefore, an individual white blood count may mean absolutely nothing—in fact, the clinician would be better off without it. One must remember that a number of serious, and at times fatal, conditions may be found either with leukocytosis or with *leukopenia.*

Considerable information, however, may be obtained from an accurately performed differential white blood count. This determination enumerates the percentages of various blood cells and alterations in their morphology. The original classification of the white blood cells according to Ehrlich has been modified by Arneth, who has classified adult polymorphonuclear cells, and Schilling, who has classified the immature polymorphonuclear cells. The other terms used in this respect are, "shift to the right" (adult polymorphonuclear cells) and "shift to the left" (immature polymorphonuclear cells). When this type of differential count is interpreted in the light of number of cells, with particular consideration of the distribution of lymphocytes and monocytes, one has accurate information in regard to diagnosis of diseases and their progress. For instance, eosinophilia is common in allergic and parasitic diseases; monocytosis is particularly prominent in bacterial endocarditis, active tuberculosis or brucellosis; and lymphocytosis is prominent in infectious mononucleosis, whooping cough, measles, or healing tuberculosis. This, of course, does not mention the leukemic variations.

A tabulation of the information gained in this type of study would be as follows:

1. A severe pyogenic infection gives a high white blood cell count and indicates that the bone marrow is competent.
2. Immature neutrophils are the keynote in such infections. If the immature cells disappear (shift to the right) and the adult cells show toxic changes, there is indication of overwhelming infection for which the bone marrow cannot compensate.
3. A shift to the left, a decreasing white blood cell count, and *toxic* changes in the neutrophils indicate overwhelming infection and poor prognosis.
4. A decreasing white blood cell count with loss of the shift to the left and gradual maturity of neutrophils indicates good prognosis. The eosinophils that return after an infection are good prognostic signs.
5. The appearance of monocytes after leukocytosis and eosinophilia is a good prognostic sign.
6. Lymphocytosis after a polymorphonuclear leukocytosis usually means reparation and healing.
7. Presence of monocytes with leukocytosis and a shift to the left indicates a severe infection such as subacute bacterial endocarditis—J. F. KUZMA, M. D., *Milwaukee.*

CHICAGO MEDICAL SOCIETY

The third Annual Clinical Conference will be held at the Palmer House, Chicago on March 4, 5, 6, and 7, 1947. Prominent men in medicine from all sections of the United States will take part in the program.

As It Looks to Your State Board of Health

(These timely discussions of health problems are prepared by staff members as a special service to Wisconsin's physicians.)

G. A. COOPER

Doctor Cooper is research associate in dermatology at the University of Wisconsin Medical School, from which he graduated in 1935. He took postgraduate work at Western Reserve University School of Medicine from 1936 until 1939.

A Diplomate of the American Board of Dermatology, the doctor is a Fellow of the American Academy of Dermatology and Syphilology.

Syphilis and Penicillin Therapy

Ever since Mahoney's publication of his important discovery that penicillin is effective in syphilis treatment there has been a profusion of articles, both lay and professional, regarding the use of penicillin for the treatment of early syphilis.

At first 1,200,000 units were recommended and the patient was instructed that he was probably cured. Then it was found that 2,400,000 units were necessary. Now, with the refinement of penicillin, it seems that some of the spirochetal activity of the drug has been removed, and consequently it has been found necessary to again increase the dosage of penicillin. Thus, we cannot assure the patient that penicillin alone will cure his syphilis.

At the present time it seems more prudent that we regard penicillin as another drug for the treatment of syphilis rather than as an answer to all syphilis treatment problems. In order to take advantage of the benefits which may be gained from the use of penicillin, it now seems best to hospitalize the patient and give him 2,400,000 units of penicillin. This is done by giving 40,000 units every three hours for a total of sixty injections. At the same time intravenous injections of mapharsen are given every other day, one milligram per kilogram body weight for a total of five injections.

On the eighth day the patient is discharged and mapharsen therapy is continued according to the "26-week plan." This consists of two injections a week of mapharsen for a period of ten weeks, making a total of twenty injections. At the time of the last injection of mapharsen the first injection of bismuth is given, and one injection a week of a fat-soluble bismuth is given for a period of six weeks. The mapharsen injections are then repeated for another ten weeks, thus giving the patient a total of forty-five injections. Mapharsen is recommended in place of other arsenicals because it can be given more safely in repeated dosage at short intervals. Following this, the patient is given a weekly injection of bismuth for ten weeks. The patient is then kept under observation and a Wassermann is taken each month for the first two months, or longer if the reaction is still positive. When negative, he is examined at two-month intervals until a year has elapsed from the onset of the treatment. At this time a spinal fluid examination should be made, and if this and the serology are negative the patient may be discharged to bi-yearly examination, with instructions to report immediately for examination if any skin lesions develop.

The above plan has been found satisfactory for the treatment of early syphilis, primary and secondary; therefore it seems to us to be the safest recommendation at the present time.

The use of penicillin in the treatment of latent syphilis of over two years' duration is still entirely in the experimental stage. While penicillin may be used as another drug in the treatment of syphilis, it is not to be relied upon without supplementary treatment with the bismuth and arsenical preparations.—GARRETT A. COOPER, M. D., *Consultant on Veneral Diseases.*

The State Board of Health announces that it has a limited supply of penicillin available for the treatment of early syphilis. While it lasts, this will be sent to private physicians upon request. The request should include the amount of penicillin desired, the name of the patient, and the stage of the disease.

As It Looks From The Council on Industrial Health

Wisconsin is but one of many state, area, or specialty medical societies. Its perspective is that of a mid-western state. But its problems, at least in part, are also problems elsewhere. These pages are provided periodically for the reactions of medical leadership in other parts of the country.

C. M. PETERSON

Doctor Peterson, a native of Rockford, Illinois, graduated from the University of Minnesota Medical School in 1927. He became associated with the Council on Medical Education and Hospitals of the American Medical Association in 1930, and became Secretary of the Council on Industrial Health of the A.M.A. when it was formed in 1938.

The centennial year for the *American Medical Association* is 1947. In connection with the celebrations planned for this event, each of the agencies in the headquarters office has prepared a history of its origin and later development. The Council on Industrial Health is less than ten years old, and therefore, one of the youngest of the standing committees. Yet, in this short time, remarkable progress has been made.

The Council felt that four major lines of activity were necessary to arouse substantial interest in the health and welfare of industrial workers. These were the creation of demand and support from management and labor, the clarification of industrial health objectives and their integration into the patterns of community medical service, improved professional training and standards, and better grass roots organization for industrial health service by individual physicians, consultants, technologists, medical societies, and health agencies. In each of these directions the record of accomplishment during the past decade is more than satisfying. However, complacency is certainly unjustified—the full opportunity in all these fields is still only partially realized.

The principal gain has been in the realm of professional acceptance. More and more physicians are realizing that in industrial health there are great possibilities for professional advancement—as administrators, consulting specialists, clinicians, and investigators. Out of this realization has come a strong demand for certification. It cannot be denied that modern industrial health, with its emphasis on preventive medicine and positive health, does call for as high a degree of training and aptitude as does any other medical specialty.

What of the coming years? The enormous impact on modern industry of nuclear physics and chemistry with their attendant hazards, the strong and growing interest in health as a factor in individual and collective security, the trend in occupational medicine towards positive health and physical fitness, the postwar concentration on rehabilitation and selective placement, together with the technical advances in industrial medicine and hygiene, all give sharp emphasis to the importance of medicine in an industrial civilization and strongly suggest the shape of things to come.—CARL M. PETERSON, M. D., *Secretary, Council on Industrial Health, American Medical Association.*

TUBERCULOSIS AND INDUSTRIAL EMPLOYMENT

A booklet, "Tuberculosis and Industrial Employment," prepared by O. A. Sander, M. D. for the Committee on Tuberculosis in Industry of the American Trudeau Society and the National Tuberculosis Association, is available to any Wisconsin physician by writing to the Wisconsin Anti-Tuberculosis Association.

. . . . THE PRESIDENT'S PAGE . . . .

Physicians Will Never Strike

A STRIKE is defined as a cessation of work on the part of workingmen to enforce their demands against the employer or to resist demands and rules made by the employer. Strikes are a feature of modern industrial organization. A lockout is a cessation of work by an employer to enforce demands on employees.

The general view of strikes and lockouts is that the interests of labor and capital are necessarily antagonistic; that they are the procedures of a purpose akin to warfare; and that the evils that attend are, therefore, justifiable as incidents of warfare. There are optimists who would put a better interpretation to the actualities of strike and walkout, but we will take the situation as we find it. That the operations are selfishly conceived in either case by one or both parties concerned, is generally admitted. The public may suffer grievous inconveniences or worse, but the only consideration given these injustices is the hope that the suffering public will wrathfully compel the other party to submit or compromise. Whatever of Christian spirit is present in these disastrous clashes is not readily apparent. There is no purpose here to attempt discriminatory censure against either party to a strike or lockout. The purpose of the preceding definitions and observations is for contrast only. I have never heard of a physicians' strike of any considerable magnitude; neither the dental or legal profession resorts to such means for advancing itself. And the reason lies in the fact that professional bodies do not approve of ethics that may bring injury to any elements of the people, unjustly, incidentally, or vicariously. When a profession has debased itself by measures that are initiated in callous selfishness it has lost the respect, comfort, and dignity of professional consciousness.

Unionism stretches or shrinks each member to the measurements of a standardized unit. There is nothing in the book to encourage the acquisition of special skill. Federalized medicine, regardless of the statements of its sponsors, would make the physician a rulebook automaton and a time clock underling.

Industrialists are chagrined because a professional man fails to harmonize with their ideas of an assembly line paradise. Their sensitive souls can not accept as reality any group that refuses to respond to the primitive urge to throw a monkey wrench into the machinery to gain a point.

And so we find in the field of human endeavor a few groups that still hold in dignity a position won by merit and maintained by continuous labor and application to the performance of the duties of their respective callings.

Physicians will never strike or promote lockouts so long as they adhere tenaciously to those professional ethics and standards that have been formulated and molded by the wisdom and devotion of our professional forbears. So long as medicine is not subjected to regimentation it will be free from the bullyragging of political overseers and the mob-tinctured activities of the picket line.

P. R. Minahan

Looking at Sickness Insurance Abroad

By J. G. CROWNHART

Just prior to his death in Cleveland in 1941, J. G. Crownhart, Secretary of the State Medical Society of Wisconsin, addressed the Health and Accident Underwriters Conference in Chicago on "Looking at Sickness Insurance Abroad." With the current hearings and discussion on the Wagner-Murray-Dingell legislation and the whole subject of compulsory sickness insurance, it seems again timely to present Mr. Crownhart's paper in The Wisconsin Medical Journal. For the convenience of the reader, the whole paper was published in the July, 1941, issue of the Journal. It will be reprinted in installments in current issues of the Journal of 1946, beginning with the June issue and continuing through the October issue.

PART V

(Continued from the September Journal)

Administration Concepts

COMPULSORY sickness insurance systems do not administer themselves without personnel or cost. Experts at the International Labour Office at Geneva stated that experience indicated that the system requires one person on the administrative staff for each fifty to a hundred persons insured. Thus this particular form of social insurance becomes by far the most expensive of all social insurances. To that same extent, moneys raised for sickness care are necessarily diverted. From my own studies I was convinced that administrative costs varied from 15 to 20 per cent when accounting included rentals on administration buildings. In order to cover the wage-earning population of Wisconsin and their dependents, for example, the administrative force would be a regiment of from 1,500 to 3,000 people, excluding the physicians who render the actual care.

As one studies at firsthand not the wording of laws but their actual operation, one is more and more impressed that the administrator, out of necessity, becomes the trustee of funds and with each succeeding year the concept of guardianship of health fades still further into a hazy background. An administrator of long experience in Berlin well expressed the common dilemma when he said to me, "Mr. Crownhart, not all our people are sick at any one time but those who become ill wish a very full measure of the benefits for which they have paid so much over a long period of time. But all I know is that last year and the years before that, I did not have sufficient funds to do all that the beneficiaries would have me do. Not knowing what demands may be made upon me by reason of unusual illness or sickness, I must guard my funds."

Nor could I find that the reported surplus for times of emergency was other than a bookkeeping balance. Separation of state funds that an administrator may have immediate access to a surplus in considerable amount is undoubtedly less feasible by far than the uninitiated might assume.

"Principle of Economy"

Throughout the entire history of compulsory sickness insurance runs the central theme of the administrator,—the operation of "the principle of economy in health benefits." These words are the exact title of a publication by the International Labour Office,—its last major publication in this field before the present war.

Medicine has its problems, but may I not direct your attention to the fact that within eighteen months* the Surgeon General of the U. S. Public Health Service declared that in no previous period of time have we made such rapid health progress. May I direct your attention to the fact that our loss of time through illness in Wisconsin is only one-tenth of that in pre-war England and by a wide margin, our record is even better when compared with the experience in pre-war Germany,—both countries that have had long experience under compulsory sickness insurance. This theme could be extended on and on for under our system, as the sickness insurance authorities so well point out, "It is, of course, the well being of his patient and not the principle of economy that is the paramount consideration of the doctor."

Medicine has never opposed, and on the contrary, has ever supported, systems of insurance that pay the recipient wholly in cash. Here no needed health service can be subtracted to balance a budget without patient awareness. Here no failure, whole or partial, can occur without immediate and effective public protest. Here economic security in a degree is not purchased at the joint expense of taxes *and* lessened efficiency of medical care and health services. Under wholly cash benefit insurance no report can be issued, as in England, wherein it was said

* During 1940–1941.

of the compulsory system, "It is no less necessary for those concerned with national health to examine the disease of insurance schemes * * * than it is to study heart disease and cancer."

The observer and student of experience abroad will not be quick to criticize what foreign governments have done to ameliorate conditions to some extent for populations of poor people, conditions that have never existed in this country. But the same observer seeking a framework upon which further to build for the continued health advance of our people comes back deeply impressed that the difficulties that I have here mentioned today, and others on which I have had no time to dwell, are inherent in the operation of compulsory sickness insurance laws.

The Real Purchase Price

I would leave you with the thought, not that we cannot have compulsory sickness insurance here or that its closely-knit proponents are not making headway to that end. I would leave you with my own conviction that such systems have their own diseases that are of such consequence that they can be classed in the same breath with heart disease and cancer; that these, rather than the money contributions, constitute the real purchase price of this so-called social legislation.

In the face of active proposals for the enactment of this legislation in our own country, is not your duty, as well as mine, to give light that the people may "find the way"?

Physicians in Service

For many months material in this section was carried under the title of "The Nation at War." With physicians still entering service, with many returning to reestablish themselves in civilian practice, and with many planning to continue in service for an indefinite time, it is the decision of the *Journal* to continue the section under a more timely title.

Military Notes

N. G. RASMUSSEN

Captain N. G. Rasmussen, formerly of the Jackson Clinic, Madison, is serving as a physician in the Army at Oliver General Hospital in Augusta, Georgia. The doctor entered the Army in June of 1945 and was stationed at Carlisle Barracks, Pennsylvania, with the 69th O. T. B. until August 1, 1945, when he was transferred to Augusta. Captain Rasmussen wears the Meritorious Service Insignia and the American Theater ribbon.

Captain Brunetto J. Haines, who practiced in Arcadia before entering military service September 9, 1943, is now a patient at Fitzsimons General Hospital in Denver. The doctor was hospitalized after returning from two years of active duty overseas as a physician in the Army with the 345th Station Comp. at Oahu, Hawaii, and with the 389th Air Service Group and the 316th Bomb Wing at Okinawa.

The doctor's first post was Station Hospital, Hunter Field, Savannah, Georgia, where he served from October 1943 to June 1944. He wears the Asiatic–Pacific Theater and Okinawa Occupation ribbons with battle stars for the Ryukyu and Okinawa campaigns.

Medical School Graduates Offered Reserve Commissions, Internships

Major General Norman T. Kirk, the Army Surgeon General, has announced that there are 83 First Lieutenant reserve commissions available for 1947 Medical School graduates who desire internships in Army hospitals.

Along with the commission goes an annual salary of $3,404 if the officer has dependents. If he has no dependents, he will receive $2,972 a year. These figures include a rental allowance of $60 monthly where government quarters are not furnished.

The commissions represent an unprecedented departure from former Army practice when interns were classified as civilian employees and received about $1,000 annually while completing their fifth or clinical year of study. With some 90,000 patients in Army hospitals the world over and prospects of a large peacetime Army, the Army Medical Department is seeking young doctors interested in a career in military medicine.

In the event that a man who receives a reserve commission does not elect to remain in the Army

following his internship or does not develop to meet requirements for Army doctors, his training will not be lost. This internship, the conventional rotating type, is recognized by the Council on Medical Education and Hospitals of the American Medical Association and by State Boards of Registration. They require the clinical year of training before granting a license to practice.

In notifying Deans of accredited medical schools of the plan, the Surgeon General has asked that they recommend men, not only desirable as interns, but who will ultimately develop as Regular Army medical officers. A professional examination will not be required before the internship is accepted.

Applications may be submitted by students through the Deans of their respective schools. Each applicant who qualifies will be notified. Application blanks may be obtained from the Deans of medical schools.

Each applicant must be a United States citizen, a prospective 1947 graduate of a recognized school of medicine approved by the Council on Medical Education and Hospitals, must be not over 30 years of age on July 1, 1947, have no commitment to accept an internship appointment in any other institution, and meet physical standards for appointment in the Medical Corps, U. S. Army. Physical qualifications are printed in Army Regulation 40–105.

Returning Veterans

P. D. ANDERSON

La Crosse practitioner, **Major Paul D. Anderson**, who entered the Army in August 1943, received a discharge June 3, and has returned to his civilian practice. Major Anderson was on active duty with the 105th Medical Battalion, 30th Infantry Division in the United States, England, France, Belgium, Holland, and Germany from September 1943 to October 1944. He then served at the ASF Regional Hospital at Fort Benning, Georgia. Major Anderson wears the European Theater of Operations and American Theater ribbons with three bronze stars. He is also a wearer of the Combat Medical Badge.

After completing three years of service in the Army, **Captain Frank J. Gallagher** received a discharge April 15 and resumed his practice in La Crosse. Captain Gallagher entered the Army in May 1943 and was assigned to the 138th Station Hospital at the Desert Training Area in California. From February to June of 1944 he served with the same unit at San Luis Obispo, California, transferring then to the 34th Hospital Train at Camp Grant, Illinois. Reporting for overseas duty, the doctor served in the European Theater of Operations with the 34th Hospital Train, the 164th General Hospital, and the 8047th General Hospital.

Captain Gallagher wears the American Defense ribbon and the European Theater of Operations ribbon with stars for the battles of Ardennes and Northern France.

Captain C. L. Budny of Milwaukee received a discharge July 11 after serving as a physician in the Army since February of 1944. Upon entering the Army, the doctor spent a few months at Carlisle MFSS, Pennsylvania, before going to Mayo Clinic, Rochester, Minnesota, for a course in surgery and surgical specialties. After several months at Stark General Hospital, Charleston, South Carolina, and one month at the Regional Hospital, Fort Jackson, South Carolina, Captain Budny was transferred to Mayo General Hospital at Galesburg, Illinois. The doctor's last post before his discharge was the War Department Personnel Center, Fort Leavenworth, Kansas. Captain Budny wears the American Theater ribbon.

Dr. James C. Cook, discharged from the Army Medical Corps June 23, has opened an office for civilian practice in Racine. He went into the armed forces July 17, 1943 from internship at Research Hospital, Kansas City, Missouri, and served with infantry and engineers regiments in this country and overseas.

Lieutenant Colonel Russell C. Darby, formerly of Mishicot, and for the past four years in the Army, has opened a practice in Wautoma. After entering the Army as a physician in July 1942, Colonel Darby served for a year and a half at the Armed Forces Induction Station in Chicago. Transferring to the Induction Station at Milwaukee, the doctor rendered service there until July 1944 when he reported to the Percy Jones General Hospital in Battle Creek, Michigan. In June of 1945 he was assigned duty at the Percy Jones Convalescent Hospital, at Fort Custer, Michigan. Colonel Darby, wearer of the American Theater ribbon and the Army Commendation ribbon, was discharged July 23, 1946.

Following a discharge from the Navy July 18, **Lieutenant Noland A. Eidsmoe** located as a civilian practitioner at Rice Lake. Lieutenant Eidsmoe's first assignment after entering the Navy September 10, 1944, was the Yard Dispensary PSNY, Bremerton, Washington. Later he served with the 100th U. S. N. C. B. at Pearl Harbor and in the Philippines; on board the USS Caldwell (D. D. 605) on the Atlantic and Pacific Oceans; and at the Separation Center, Minneapolis.

Lieutenant Eidsmoe is entitled to wear the Asiatic–Pacific Theater, Philippine Liberation, and American Theater ribbons.

Lieutenant Colonel Richard W. Farnsworth, who was in practice in Janesville before he went into the Army, in July 1942, received a discharge June 15, 1946. The doctor has now resumed his Janesville practice.

Colonel Farnsworth's military record shows he was on active duty at the Station Hospital, Fort Knox, Kentucky; with the 44th General Hospital at Fort Sill, Oklahoma, in Australia, on Leyte, Philippine Islands; and at the Percy Jones General Hospital, Battle Creek, Michigan. He wears the American and Pacific Theater ribbons and the Philippine Liberation ribbon, and has battle stars for the New Guinea and Philippine campaigns.

Lieutenant William A. Fischer who was discharged from the Army Medical Corps August 26, has joined the staff of the Frederic Clinic in Frederic. A resident physician at the Wisconsin General Hospital, Madison, until he entered the armed forces, the doctor served with the Army for fifteen months, including five months overseas where he was stationed at Munich, Germany.

F. G. GAENSLEN

After two years of active duty with the Navy, **Lieutenant Frederick G. Gaenslen**, former resident physician in Madison, received a discharge July 15, and has started a practice in Milwaukee. Upon reporting for duty July 1, 1944, Lieutenant Gaenslen was assigned to the U. S. Naval Hospital at Oakland, California. Later he served at the Naval Air Station, San Diego, California; on board the USS Shadwell (LSD 15) and the USS Joseph T. Dickman (APA 13) on the Pacific Ocean; and again at the naval hospital in Oakland. Lieutenant Gaenslen wears the Pacific Theater (with one star), Philippine Liberation (with one star), and the American Theater ribbons.

After an absence of three years, **Captain A. M. Bachhuber** has returned to Kaukauna to resume his civilian practice that was interrupted when he went into the Army in May 1943. The doctor served with the 130th Station Hospital at Swinden and Plymouth, England; Heidelberg, Germany; Chiseldon, England, and Camp Lucky Strike, France. A wearer of the European Theater of Operations ribbon, Captain Bachhuber was discharged April 17.

Commander William H. Bennett, former Kenosha practitioner was discharged from active duty with the Navy March 26, after serving in this country and in the Pacific since July 6, 1943. The doctor is now practicing in Racine.

Commander Bennett rendered service at the following stations: Naval Station, New Orleans; Fleet Hospital #110 and NAB Dispensary, Russell Islands; and the U. S. Naval Hospital, Great Lakes, Illinois. He wears the American and Pacific Theater ribbons.

Captain John F. Poser of Columbus, who entered the Army Medical Corps in August 1944, was discharged September 16, 1946. He has returned to his practice in Columbus and is also practicing in Madison.

Doctor Poser's two years as a physician in the Army were spent at the following posts: Carlisle Barracks, Pennsylvania; the University of Pennsylvania, Philadelphia; Percy Jones General Hospital, Battle Creek, Michigan; Mayo General Hospital, Galesburg, Illinois; and Lawson General Hospital, Atlanta, Georgia. Captain Poser wears the American Theater ribbon and has the Meritorious Service Award.

Captain Joseph D. Postorino has returned to Racine to start his practice of medicine following a release from active duty June 30. His terminal leave expired September 9. After entering the Army Medical Corps in January of 1944, Captain Postorino served in New Orleans, at the Army–Navy Hospital, Hot Springs, Arkansas, and in Long Beach, California.

Former Madison practitioner, **Major Jackman Pyre** was discharged from the Army March 16, and has located as a civilian practitioner in Tuscon, Arizona. During his almost four years of service, that started in June 1943, Major Pyre was stationed with the 44th General Hospital at Fort Custer, Michigan; at Fort Sill, Oklahoma; in Townsville, Australia; and on Leyte, Philippine Islands. On detached service he was with the 839th Clearing Company at Santo Tomas, Manilla, Philippine Islands. Major Pyre wears the Asiatic–Pacific Theater ribbon with three bronze stars and was awarded the Bronze Star Award.

A. B. KORES

Major Ambrose Kores of Beaver Dam, who entered the service shortly after his graduation from Marquette University School of Medicine in August 1944, was recently discharged from the Army Medical Corps. He is now associated with **Dr. R. F. Schoen** in the practice of medicine in Beaver Dam. Major Kores served with the 30th Division as surgeon. While in service in England the doctor was with the 56th General Hospital. He was with the invasion forces and was wounded at St. Lo on July 5, 1944. The doctor was then sent to England for medical treatment and later returned to this country for further treatment.

In the United States Major Kores served at the following hospitals: Percy Jones, Battle Creek, Michigan; Kennedy General, Memphis, Tennessee; and the Station Hospital, Fort Sheridan, Illinois.

Lieutenant Colonel E. L. Lochen, former Waukesha practitioner, after almost six years as a physician in the Army, received a discharge January 15. Colonel Lochen went on active duty November 7, 1940, serving at the Station Hospital at Chanute Field, Illinois; in the Hawaiian Islands; with the 4th Army at Camp Barkeley and Camp Swift in Texas; and at the William Beaumont General Hospital, El Paso, Texas. Colonel Lochen, who is a wearer of the Pacific Theater and Pre-Pearl Harbor ribbons, practiced at Frederic, Oklahoma, for eight months after his discharge.

Captain Fred S. Marshall, resident in orthopedic surgery at Shriner's Hospital in Chicago before he entered the Army, November 1942, received a discharge April 9. Upon completion of his orthopedic training the doctor plans to begin medical practice in Appleton.

Lieutenant Colonel Charles H. Kingsbury, former Goodman physician, has started his civilian medical practice in Florence, South Carolina. The doctor was discharged from the Army March 26, having served since June 1941.

Colonel Kingsbury served at Station Hospital, Fort Bliss, Texas; with the 38th Infantry at Fort Sam Houston, Texas; and with the 362d Engineers Regiment in the Pacific Theater. A veteran of almost four years of overseas duty, Colonel Kingsbury wears the American Defense, American Theater, Asiatic–Pacific Theater, and Philippine Liberation ribbons.

Captain Marshall's record shows that he rendered service as a physician in the Army at the following posts: Station Hospital, Fort Custer, Michigan; 182d Station Hospital, Camp Breckinridge, Kentucky; 688th Medical Hospital Ship Platoon at Camp Patrick Henry, Virginia, in India, the Middle East, North Africa, Italy, France, and England; and Northington General Hospital, Tuscaloosa, Alabama.

He is a wearer of the China–Burma–India, European–African–Middle Eastern, and American Theater ribbons with one star for the third battle of Germany.

J. L. NELLER

Lieutenant James L. Neller, former resident-instructor in surgery at Wisconsin General Hospital, Madison, was discharged from the Navy July 11 after serving since July 1944. He is now graduate resident in surgery at Wisconsin General Hospital. While in the Navy Lieutenant Neller served at the U. S. Naval Hospital, San Diego, California; at the U. S. Naval Advanced Base Personnel Depot, San Bruno, California; with Standard Landing Craft Unit #40 in the Pacific (Philippine and Ryukyu Islands); at Section Base on Okinawa; and at Fleet Hospital 116 on Okinawa, where he was in charge of general surgery. Lieutenant Neller wears the American and Asiatic–Pacific Theater, Philippine Liberation and Ryukyu Occupation ribbons with one star on the Asiatic–Pacific ribbon for the invasion of Keramo Retto and Okinawa.

Lieutenant Commander Francis L. O'Keefe of Delavan was discharged from the Navy Medical Corps January 4, and has resumed his practice. Commander O'Keefe entered the service July 26, 1943, the first professional man from Delavan to give his services to the Navy in World War II. The doctor reported for duty first at San Diego, California, serving later at U. S. Naval Base Hospitals in the South Pacific. Commander O'Keefe is a wearer of the Asiatic–Pacific and Southwest Pacific Theater ribbons.

Dr. William Hovis, Jr., of Milwaukee, who was recently discharged from the Navy after serving two years in the Pacific Theater with the amphibious forces, has opened offices in Wauwatosa with **Dr. M. Alex Krembs,** former Chicago physician and also a Navy veteran. The doctors are specializing in gynecology and obstetrics.

Former Brillion ophthalmologist, **Lieutenant Colonel A. J. Wagner**, received a discharge from the Army January 16 after serving since November 5, 1940. At the time of his detachment from the armed forces the doctor planned to spend some time at Wesley Hospital in Chicago, and then start a practice in Janesville. Among the places at which Colonel Wagner was stationed during his five years as a physician in the Army are: Scott Field, Belleville, Illinois; Kellogg Field, Battle Creek, Michigan; Tampa, Florida; Greenville and Myrtle Beach, South Carolina; and Fort Wayne, Indiana.

Major Samuel Wick, formerly of Wauwatosa, received a discharge from the Army July 26, and opened offices in Las Vegas, Nevada. The doctor was called to active duty in November 1942, and attended Officer Training School at Miami Beach, Florida. Major Wick was then assigned to Jefferson Barracks, Missouri, as assistant chief of the neuropsychiatric service until April 1944, when he was transferred to Las Vegas Army Air Field. He served as chief of the neuropsychiatric service there until his discharge.

L. L. SWAN

A former resident physician at Wisconsin General Hospital, Madison, **Major Lawrence L. Swan**, was discharged from the Army August 7 after four years of active duty. As a civilian now, the doctor is pathologist at the Army Institute of Pathology in Washington, D. C.

Upon entering the Army in August 1942, Major Swan was assigned to Fort Leavenworth, Kansas, as chief of laboratory service. Later he served as pathologist at the Army Medical Museum, Histopathological Center, Fitzsimons General Hospital, Denver, and as surgical pathologist and assistant chief of laboratory service at Fitzsimons. Major Swan is a wearer of the American Theater ribbon.

On August 4, **Captain Eugene J. Usow** was released from active duty in the Medical Corps of the Army after serving for the past two years. He plans to resume his Milwaukee practice.

Captain Usow served as a battalion surgeon in the 805th Tank Destroyer Battalion and saw action in the Italian campaign on the 1944 Winter Line, as well as in the Northern Appennines and Po Valley campaigns. Upon his return to the United States after duty in the European Theater of Operations, the doctor served as a dispensary surgeon and as chief of the dispensary service at North Camp Hood, Texas. Later he was assigned to Wakeman General Hospital at Camp Atterbury, Indiana, where he was on duty as a ward surgeon. Captain Usow then became instructor in surgery in the Enlisted Technicians School of the Medical Department at the same station.

Captain Usow is entitled to wear the African and Middle East Theater ribbons with two bronze stars and the American Theater ribbon.

Major Frederick D. Geist returned to Madison to resume his position as associate professor of anatomy at the University of Wisconsin following almost four years of service as a physician in the Army. Major Geist went on active duty July 2, 1942. He was discharged from the Army March 14, 1946 after serving at the following stations in this country and overseas: Fitzsimons General Hospital, Denver; 48th Surgical Hospital (which later became the 128th Evacuation Hospital) in England and North Africa; 2d Convalescent Hospital, North Africa; Hoff General Hospital, Santa Barbara, California; and McCaw General Hospital, Walla Walla, Washington.

Major Geist is a wearer of the American Theater ribbon and the North Africa Theater ribbon with stars for the invasion of North Africa and the Tunisian campaign.

Major Gerhard D. Straus has resumed his Milwaukee medical practice following over three and one-half years of service as a physician in the Army. Major Straus, a wearer of the American Theater ribbon, entered the armed forces in October of 1942 and was discharged August 11.

W. C. KEETTEL

Former Madison practitioner, **Captain William C. Keettel**, was discharged from the Army September 3 and accepted the position of assistant professor of obstetrics and gynecology at the University of Iowa Medical School, Iowa City, Iowa. Captain Keettel entered the Army in December 1943, and served from then until June 17, 1946 with the Manhattan District at Oak Ridge, Tennessee. He is a wearer of the Army Commendation ribbon and was awarded the Meritorious Service Plaque.

Milwaukee physician, **Major Marcus M. Guzzetta** returned to his civilian practice after receiving a discharge from the Army February 4. Entering the armed forces in February 1941, the doctor served at

the following Army stations: 4th Medical Supply Depot, Fort Sam Houston, Texas, 1941; 4th Medical Supply Depot, Iceland, 1941–43; 50th Field Hospital, Camp Atterbury, Indiana, 1943; Nichols General Hospital, Louisville, Kentucky, 1944; 5th Service Command, Fort Knox, Kentucky, 1944; and 9th General Hospital, Biak, New Guinea, 1945.

Major Guzzetta is entitled to wear the American Theater, European Theater, Southwest Pacific Theater, Pre-Pearl Harbor, and Philippine Liberation ribbons.

Recent Releases From Service*

Physicians and Location	Date Discharged
Anderson, P. D., La Crosse	June, 1946
Ansfield, M. J., Milwaukee	November, 1945
Atwood, D. C., Madison	February, 1946
Bennett, W. H., Kenosha	April, 1946
Bergen, R. D., Milwaukee	February, 1946
Bloom, C. S., Wausau	April, 1946
Budny, C. L., Milwaukee	July, 1946
Charles, J. D., Milwaukee	May, 1946
Christofferson, J. W., Waupaca	June, 1946
Crumpton, C. W., Madison	April, 1946
Darby, R. C., Mishicot	July, 1946
Detjen, E. D., Green Bay	July, 1946
Eckstam, E. E., Madison	May, 1946
Eidsmoe, N. A., Rice Lake	July, 1946
Emrich, P. S., Oshkosh	August, 1946
Farnsworth, R. W., Janesville	June, 1946
Flaherty, G. S., Milwaukee	June, 1946
Gaenslen, F. G., Milwaukee	July, 1946
Gallagher, F. J., La Crosse	April, 1946
Geist, F. D., Madison	March, 1946
Hamilton, W. P., Dodgeville	April, 1946
Hansen, H. J., Sheboygan Falls	May, 1946
Harris, A. J., Adams	February, 1946
Heil, J. V., Hales Corners	January, 1946
Hoffman, C. W., Wauwatosa	July, 1946
Hogben, C. A. M., Madison	September, 1946
Hovis, W. F., Milwaukee	June, 1946
Jensen, R. A. Menasha	February, 1946
Kaufman, L. W., Milwaukee	February, 1946
Keettel, W. C., Madison	September, 1946
Kern, E. E., Mukwonago	May, 1946
Kingsbury, C. H., Goodman	March, 1946
Klockow, W. E., Richland Center	January, 1946
Limberg, P. W., Plymouth	December, 1945
Lochen, E. L., Waukesha	January, 1946
Margoles, Milton, Milwaukee	December, 1945
Marshall, F. S., Chicago	April, 1946
Martini, H. F., Wausau	January, 1946
McCormick, D. W., Madison	December, 1945
Merten, A. N. E., Milwaukee	October, 1946
Neller, J. L., Madison	July, 1946
Newcomb, C. J., Milwaukee	December, 1945
O'Keefe, F. L., Delavan	January, 1946
Olsen, L. C., Delafield	December, 1945
Paulson, J. F., Sun Prairie	May, 1946
Peabody, C. S., Madison	January, 1946
Perssion, L. B., Winnebago	March, 1946
Pohle, H. W., Milwaukee	February, 1946
Poser, J. F., Columbus	September, 1946
Prudowsky, H. H., Milwaukee	April, 1946
Pyre, Jackman, Madison	March, 1946
Reslock, C. P., Waupun	June, 1946
Sagi, J. H., Milwaukee	February, 1946
Schroeder, J. D., Janesville	September, 1946
Sharpe, H. R., Jr., Fond du Lac	September, 1946
Stadel, E. V., Reedsburg	March, 1946
Stern, Louis, West Allis	March, 1946
Straus, G. D., Milwaukee	August, 1946
Swan, L. L., Madison	August, 1946
Tausend, H. J., Madison	March, 1946
Usow, E. J., Milwaukee	July, 1946
Vander Kamp, Harry, Baraboo	March, 1946
Wagner, A. J., Janesville	January, 1946
Wick, Samuel, Milwaukee	July, 1946
Waldkirch, B. P., Milwaukee	September, 1946
Wyant, M. E., Hayward	March, 1946
Zawodny, S. E., Milwaukee	January, 1946
Zubatsky, D. J., Milwaukee	December, 1945

* Members of the State Society listed in boldface.

VETERAN PHYSICIANS' EXCHANGE

This section will be devoted to classified ads, open without charge to: (a) veteran members desiring location and (b) other members having professional openings suitable for men returning from military service.

LOCATIONS WANTED

ASSOCIATION WANTED: Navy veteran (2 yrs), age 27, discharged in July, a graduate of the University of Wisconsin in 1943, desires association or assistantship with qualified surgeon or established general practitioner, leading to partnership. Address No. 134 in care of the Journal.

LOCATION WANTED: Veteran physician with 2 years Army service, married, and former resident of Milwaukee desires an assistantship with an obstetrician preferably in Milwaukee. Graduate of Marquette University in 1943, and rotating internship at St. Agnes Hospital, Fond du Lac, Wis. Eligible for release from the Army in November, 1946. Address No. 133 in care of the Journal.

ASSISTANCE WANTED

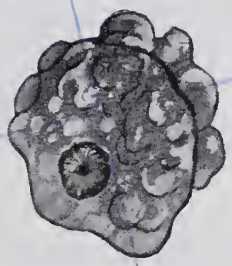
LA CROSSE PRACTICE: Unusual opportunities in La Crosse. Office space available and help in contacts. See ad on page 1014 for details.

VETERAN PHYSICIANS: This is a strategic time to enter public health. State Board of Health has 2 openings for physicians with executive ability as directors of the tuberculosis and venereal disease divisions. Salary $4,800 to $5,400 plus necessary traveling expenses, Madison headquarters. 5 district health officers also needed. If you were under 40 when entering the armed services and can otherwise qualify, write Dr. Carl N. Neupert, State Health Officer, Madison 2, Wisconsin.

WANTED: Staff physician at sanatorium approved for tuberculosis residency. Beginning salary $250–$300, less modest maintenance deduction. One position open after July 1. Wisconsin licensure required. Person must have good professional and personal qualities. Write Superintendent, Wisconsin State Sanatorium, Statesan, Wisconsin.

For additional classified advertisements, see the Physicians' Exchange, page 1014.

practically everywhere



. . . including the temperate zones, an unexpectedly high percentage of carriers of Endamoeba histolytica is to be found.

DIODOQUIN

(5,7-diiodo-8-hydroxyquinoline)

—potent amebicide—can be used in suspected as well as proved cases of amebiasis.
Accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

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SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

Society Proceedings

Brown—Kewaunee—Door

Dr. P. R. Minahan, president of the State Medical Society, and Mrs. A. J. McCarey, president of the Auxiliary of the State Society were guests of honor at the first fall meeting of the Brown–Kewaunee–Door County Medical Society, held at the Beaumont Hotel, Green Bay, September 12.

Doctor Minahan was presented with an engraved silver photograph holder by the county society, and the county auxiliary gave Mrs. McCarey a corsage. Both honor guests spoke briefly.

Mr. C. H. Crownhart, secretary of the State Medical Society, as guest speaker, discussed the care of veterans, the present distribution of physicians in the state, and the need for nursing education.

Eau Claire—Dunn—Pepin

Meeting September 30 at the Hotel Eau Claire, in Eau Claire the members of the Eau Claire–Dunn–Pepin County Medical Society heard an address, "Management of the Allergic Patient," presented by Dr. E. M. Rusten of the department of allergy, University of Minnesota.

Jefferson

Meeting at the Lake Mills home of Mrs. Gust Roehl, September 19, the Jefferson County Medical Society members heard a speech presented by *Dr. Howard L. Correll* of Milwaukee. Doctor Correll's subject was "Recognition of Common Heart Disorders."

Manitowoc

At a recent meeting of the Manitowoc County Medical Society, new officers were elected. They are as follows: *Drs. R. W. Hammond*, Manitowoc, president; *W. A. Rauch*, Manitowoc, vice-president; and *S. L. Weld*, Two Rivers, secretary-treasurer.

Marathon

A business and scientific meeting was held by the Marathon County Medical Society September 25 at the Hotel Wausau, Wausau. Preceding the business session, *Dr. W. T. Becker* of Wausau presented a paper on "Streptomycin" of which the laboratory phase was discussed by *Dr. O. R. Kelley*, also of Wausau.

Outagamie

Outagamie County Medical Society members met at the Riverview Country Club, Appleton, September 18, for a late afternoon golf match.

Trempealeau—Jackson—Buffalo

The Trempealeau–Jackson–Buffalo County Medical Society held its first fall meeting in the Annex Hotel, Arcadia, September 19. The members discussed a vaccination and immunization plan for the coming year.

Walworth

The Walworth County Medical Society held its monthly meeting September 12. The members present discussed the benefits of having an American Board of General Practitioners.

Waukesha

Members of the Waukesha County Medical Society paid tribute to *Dr. Richard E. Davies* of Waukesha on the completion of his fiftieth year in the practice of medicine, at a dinner at Waukesha Memorial Hospital September 4. Doctor Davies served as president of the hospital board of trustees for many years and was instrumental in planning both the hospital and the old Municipal Hospital that now serves as the city hall.

Dr. F. J. Woodhead served as toastmaster at the dinner, and the Rev. Daniel Williams of Wales, recalled the boyhood of the guest of honor. Other speakers included *Drs. Michael Wilkinson*, Oconomowoc; *Herbert Barnes*, Delafield; *J. J. Fitzgerald*, Eagle; *John Kelly*, Pewaukee; *W. B. Campbell*, *U. J. Tibbitts*, and *Martin J. Werra*, all of Waukesha; and Miss Caroline Herrl, superintendent of Waukesha Memorial Hospital.

Following graduation from Rush Medical College, Chicago, in 1896, Doctor Davies practiced in Dousman for two years before moving to Waukesha where he has remained ever since, serving the community as physician and surgeon.

Winnebago

Two physicians from the Monroe Clinic in Monroe presented speeches before the members of the Winnebago County Medical Society gathered for a dinner meeting at the Athearn Hotel in Oshkosh September 5.

Dr. W. B. Gnagi spoke on the subject, "Results in 100 Gastrectomies," and *Dr. J. A. Schindler* titled his address "Anemia."

Sixth Councilor District

The spirit of the plan for the Wisconsin Veterans Medical Service Agency, considered by the Veterans Administration as a model for states, is that the veteran has the choice of going to his own physician, *Dr. J. S. Supernaw*, Madison, chairman of the operating committee of the agency, told a large delegation of members, their wives and guests attending the Sixth Councilor District Medical Society's banquet at Hotel Retlaw, Fond du Lac, September 17.

The addresses by Doctor Supernaw and *Dr. P. R. Minahan*, president of the State Medical Society,

Information!

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Q. What are the ingredients in Campbell's Strained Baby Soups?

A. Campbell's use carefully selected meats, cereals and those vegetables scientifically recognized as having the most desirable nutritive qualities. All the food properties are natural. Because Campbell's are accustomed to purchasing only selected meats and vegetables, the best is assured for Campbell's Strained Baby Soups.

Q. What about vitamin and mineral retention?

A. The latest scientific information has been drawn upon in the development of a cooking method to insure the effective conservation of vitamins and retention of minerals.

Q. When should Baby be started on strained soups?

A. Campbell's Strained Baby Soups can be started as early as any strained baby foods. Depending upon the baby, pediatricians recommend beginning between the ages of three and six months.

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A. Every mother wants her baby's food to be palatable. Campbell's preparation and cooking methods have been devised to retain natural flavors insofar as possible. Babies develop food preferences early, accept some foods, reject others. Their acceptance of Campbell's Strained Baby Soups is indicated by the increasing demand for these soups wherever they have been introduced.

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following the banquet, concluded the first postwar meeting of the district society. *Dr. S. E. Gavin* of Fond du Lac, district councilor, served as toastmaster at the dinner.

Preceding the dinner, an afternoon technical program was held. The program began with an address by *Dr. Max J. Fox,* medical director of South View Hospital, Milwaukee, and associate professor of medicine at Marquette University, entitled "Diagnosis and Treatment of Pyogenic Meningitis."

Other speakers at the afternoon session were *Dr. William Hovis,* associate professor of gynecology and obstetrics, Marquette University, who discussed "Primary Dysmenorrhea"; Dr. Paul F. Dwan, associate professor of pediatrics at the University of Minnesota, who talked on "Recent Developments in Rheumatic Fever"; and *Dr. Ovid O. Meyer,* professor of medicine at the University of Wisconsin, who chose "What's New in Hematology?" as his subject.

Seventh Councilor District

A dinner meeting of the Seventh Councilor District Medical Society was held at the La Crosse Country Club, La Crosse, September 11, at which Dr. D. R. Nichols of the Mayo Clinic, Rochester, Minnesota, was guest speaker. His subject was "The Youth of Streptomycin in Medicine."

Wisconsin Surgical Society

A new medical organization known as the Wisconsin Surgical Society was formed at a meeting in Milwaukee attended by fifty Wisconsin surgeons September 14.

Dr. F. Gregory Connell, Oshkosh, was elected president, *Dr. Russell Kurten,* Racine, president-elect; *Dr. Warner Bump,* Rhinelander, was named secretary-treasurer; and *Dr. Frank Weeks,* Ashland, recorder.

Council members chosen were: *Drs. Sigurd Gundersen,* La Crosse; *Alfred Mayfield,* Kenosha; *Thomas Snodgrass,* Janesville; *Forrester Raine,* Milwaukee; *Arnold S. Jackson,* Madison; and *Carl Eberbach,* Milwaukee.

Meetings of the organization will be held three times yearly, in September, February, and May. However, this year the fall meeting is being planned for November 15. Dr. Fred Coller, professor of surgery at the University of Michigan will make the chief address at that meeting.

American Academy of Allergy

The American Academy of Allergy is scheduling its annual convention for November 25, 26, and 27, 1946 at the Hotel Pennsylvania, New York City. In order to bring to the medical profession the latest methods of diagnosis of cases with allergic manifestations, the Academy invites all interested physicians throughout the country to attend the convention as the guests of the Academy without payment of a registration fee.

Central Wisconsin Society of Ophthalmology and Otolaryngology

Meeting at the Northland Hotel in Green Bay, September 21 and 22, the Central Wisconsin Society of Ophthalmology and Otolaryngology elected the following officers for the ensuing year: Dr. W. S. Jones, Menominee, Michigan, president; *Dr. J. W. Tanner,* Eau Claire, vice-president; and *Dr. G. L. McCormick,* Marshfield, secretary.

The two day session included scientific speeches, round-table discussions, medical motion pictures, and recreational activities.

AND ABOUT THE THIRD DISTRICT:

"With a marked concentration of physicians in the Third Councilor District, the *Journal* is assembling all news items pertaining to activities of physicians in Dane, Rock, Green, Columbia, Sauk, Marquette and Adams Counties and presents them together. The *Journal* urges county secretaries to send personal items of interest. Such notices should reach our office by or before the fifteenth of each month before publication."

—Editor's Note

SOCIETY PROCEEDING

Dane

The Dane County Medical Society had an afternoon of recreation and business September 10 when they met at the Stoughton Country Club in Stoughton. Members played golf, and after a meeting of the Board of Trustees, gathered for dinner at the club.

COUNCILOR DISTRICT NEWS

Doctor Jackson Speaks at Superior

Dr. Arnold S. Jackson of the Jackson Clinic, Madison, addressed the Interurban Society, which is composed of doctors of Duluth and Superior, at Superior, September 18. His subject was, "New Methods of the Treatment of Toxic Goiter."

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THIRD DISTRICT PHARMACISTS

The pharmacies listed in this section have been recommended as rendering the type of prescription service in keeping with high medical standards.

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Phone: Fairchild 3400

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★ ROCK COUNTY ★

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Madison Surgeon Named Civilian Consultant

WILLIAM S. MIDDLETON

Dr. William S. Middleton, dean of the University of Wisconsin Medical School, Madison, is one of 111 outstanding physicians, surgeons, and psychiatrists of the nation appointed as civilian consultants to the Secretary of War through the Surgeon General, the War Department announced recently. Doctor Middleton specializes in internal medicine.

The appointments bring the number of civilian consultants in the Army Medical Department to more than 200. Major General Norman T. Kirk, the Surgeon General of the Army, under whose direction the armed services' medical consultant program was initiated during the war, said the appointments are aimed at maintaining the highest standards of medical practice. The consultants will augment the Army staff of doctors caring for soldier patients and evaluate, promote and improve, wherever possible, the quality of medical care given American soldiers. General Kirk also said that most of the appointees were veterans of medical service during the past war and thoroughly familiar with administrative and professional technics employed in the Army's hospital system.

Doctor Middleton served with the Army Medical Corps as chief consultant in medicine to the Surgeon General of the European Theater for over three years. He was discharged as a Colonel August 28, 1945.

Doctor Carns is Physical Education Director

MARIE L. CARNS

Dr. Marie L. Carns, associate professor of medicine at the University of Wisconsin was recently named director of the university department of physical education for women, succeeding Professor Blanche M. Trilling, who resigned recently after serving for thirty-five years in the capacity of director.

Doctor Carns, who was acting departmental director last semester, took over her director duties at the beginning of the fall term.

Dr. Carol Rice on University Staff

Dr. Carol M. Rice, who joined the faculty of the University of Wisconsin Medical School recently is serving as associate professor of clinical medicine and assistant director of the student health service at the University.

Doctor Rice returns to the University of Wisconsin Medical School after an absence of several years. During that period she has been director of the health service at Sweet Briar College in Virginia.

She holds a B. A. degree from Smith College and a Masters degree from Wellesley College. Doctor Rice was granted the degree of Doctor of Medicine by the University of Wisconsin in 1931. She served an internship and a residency in medicine and neuropsychiatry at Wisconsin General Hospital, and did graduate work in Vienna, Austria.

Dr. J. F. Paulson Moves to Eau Claire

Dr. Jerome F. Paulson, who has been associated with *Dr. L. W. Peterson* and *Dr. E. J. Nelson* in the practice of medicine in Sun Prairie, left about the first of October for Eau Claire. In that city he entered practice with *Dr. John Lowe.* Doctor Paulson was discharged from military service in February after serving for twenty-eight months overseas and in this country.

Doctor Hibma Leaves the University

Dr. Otto V. Hibma, former member of the Wisconsin General Hospital surgical staff and instructor in surgery at the University of Wisconsin Medical School, has resigned from the university staff and opened offices for private practice in Madison, specializing in surgical diagnosis and general surgery. Doctor Hibma received his medical degree from the University of Wisconsin Medical School in 1939 and took his interne work in Cincinnati, Ohio. He then served a three year residency in general surgery at Wisconsin General Hospital before accepting the position as instructor and staff member, that he recently resigned.

SOCIETY RECORDS

New Members

William F. Hovis, Jr., 8500 West North Avenue, Wauwatosa.

Gilbert O. Horn, 263 Prospect, Oshkosh.

John E. Kreher, 522 West Second Street, Ashland.

Cary S. Peabody, 1300 University Ave., Madison.

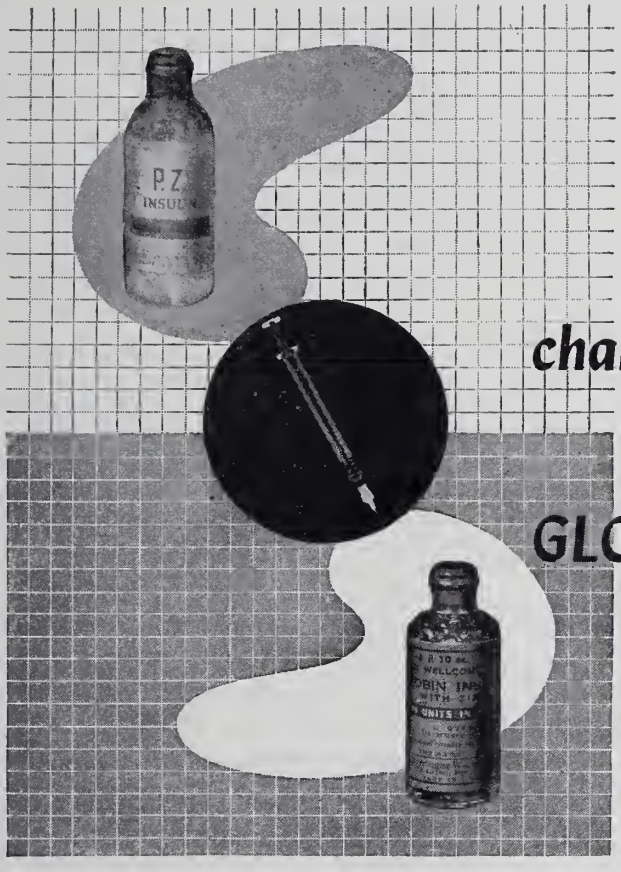
William L. Waskow, 16 South Henry Street, Madison.

John K. Curtis, 110 East Main Street, Madison.

Martin A. Krembs, 8500 West North Avenue, Wauwatosa.

Henry L. Vogl, 435 East Lincoln Avenue, Milwaukee.

Harry R. Weil, 525 East Michigan Avenue, Milwaukee.



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Most mild and many moderately severe cases may be controlled by *one daily injection of 'Wellcome' Globin Insulin with Zinc.* Vials of 10 cc.; 40 and 80 units per cc. Developed in The Wellcome Research Laboratories, Tuckahoe, New York. U.S. Pat. 2,161,198. Literature on request.

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John F. Bresnahan, Veterans Administration Facility, Wood.

David N. Goldstein, 625 Fifty-Seventh Street, Kenosha.

Howard V. Sandin, 618 Eighth Avenue, West, Ashland.

Will G. Merrill, 1431 Osborn Avenue, Washburn.

Norman J. Helland, Mt. Horeb.

Noland A. Eidsmoe, Rice Lake.

Emory R. Strauser, Mercy Hospital, Neenah.

Changes in Address

B. K. Ozanne, Neenah, to Salt Lake City, Utah.

A. C. Florin, Madison, to 1673 Mt. View Avenue, San Bernardino, California.

J. W. Kleinboehl, Mercer, to 231 West Wisconsin Avenue, Milwaukee.

E. P. Rohde, Merrill, to Argyle.

W. J. Hanley, Milwaukee, to 7139 West Greenfield Avenue, West Allis.

A. J. Wagner, Janesville, to Wesley Hospital, Chicago, Illinois.

E. D. Wilkinson, Milwaukee, to 5929 West Burnham Street, West Allis.

C. W. Stoops, Platteville, to University Hospital, Ann Arbor, Michigan.

W. L. Coon, Wood, to 5613 West Michigan Street, Milwaukee.

R. A. Jubelirer, Wilmette, Illinois, to Jewish Hospital, Cincinnati, Ohio.

S. J. Seeger, Texarkana, Texas, to 930 Mercantile Bank Building, Dallas 1, Texas.

H. E. Fillbach, Cuba City, to Bailey's Harbor.

F. A. McIver, Madison, to RFD #4, Darlington, South Carolina.

R. R. Davis, Madison, to Luthern Hospital, La Crosse.

P. W. Limberg, Plymouth, to Glenwood City.

F. D. Geist, Wellfleet, Massachusetts, to 436 Jean Street, Madison.

W. A. Fischer, Madison, to Frederic Clinic, Frederic.

C. H. Kalb, Grafton, to 3047 North Prospect Avenue, Milwaukee.

A. R. Baier, Oshkosh, to 720 North Jefferson Street, Milwaukee.

L. J. Earney, La Crosse, to 5929 North Washington Boulevard, Milwaukee.

P. R. McCanna, Milwaukee, to Burlington.

L. L. Sanford, Wood, to Hillsboro.

W. E. Klockow, Richland Center, to Muscoda.

G. C. Owen, Washington, D. C., to 910 Grand Avenue, Racine.

G. B. Merline, New Holstein, to 708 North Ashland Street, Green Bay.

A. M. Hogben, Riverdale, Maryland, to Mayo Clinic, Rochester, Minnesota.

DEATHS

Milwaukee physician and surgeon, **Dr. Cletus K. Ziegler**, died at a Milwaukee hospital Friday, September 13, after a short illness. He was 46 years old.

The doctor, born in Adell, Wisconsin, moved to Milwaukee in 1913. After graduating from the Marquette University School of Medicine in 1925, Doctor Ziegler started the practice that he continued until his death.

He was a member of the Medical Society of Milwaukee County and the State Medical Society.

Doctor Ziegler is survived by his wife and eleven children, five daughters and six sons.

Dr. Julius A. Schmidt, 70, died at his Milwaukee home Wednesday, September 11, after an eight month illness. Doctor Schmidt, a 1904 graduate of the Milwaukee Medical College, had practiced in Milwaukee since 1928, and was a member of the staff of Deaconess Hospital.

After graduation from medical school he started a general practice in Brillion, serving the community for about twenty-five years. During that time Doctor Schmidt served for many years as health officer of the village and town of Brillion, and of Maple Grove and Rantoul.

The doctor was a member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association. While practicing in Brillion he served as secretary of the Calumet County Medical Society for a number of years.

Surviving Doctor Schmidt are his wife and two sons, one of whom, Dr. Edmund J. Schmidt, will take over his father's practice.

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News Items and Personals

MEMORIAL SERVICES

Memorial services for six Milwaukee physicians who gave their lives in World War II were held in Ward Memorial Hall at Wood, Wisconsin, September 4. The dedicatory service, sponsored by the Medical Veterans Association of Milwaukee, was conducted as follows:

1. Posting of the Colors
2. Invocation ..... Chaplain Lesher
3. Tribute:

Commander Charles John Allen
Lt. William P. Wendt

Lt. Commander George William Fox
Lt. Comdr. John Charles

Captain Anthony J. Gramling
Col. Maurice Hardgrove

Major Jacob J. Horowitz
Major Robert A. Frisch

1st Lt. William Henry Millman
Lt. George E. Collentine

Captain John H. Pepin
Lt. Col. Carl Beck

4. Address ..... Captain James A. Sargent
5. Benediction ..... Chaplain Holzem
6. Taps ..... Station Bugler
7. Retiring of the Colors.

Doctor Green Takes Special Polio Training

Dr. Donald M. Green of Wausau has returned to that city after completing a physician's specialized course in poliomyelitis at Knickerbocker Hospital, New York, through the cooperation of the Marathon County Chapter of the National Foundation for Infantile Paralysis.

The courses, which were established in fall of 1945 by the Foundation's Greater New York Chapter and the national headquarters, provide training for physicians and nurses in the modern methods of diagnosis and treatment of infantile paralysis. Director of the poliomyelitis center is Dr. Philip M. Stimson, who was sent by the National Foundation to Kenosha in August to help combat outbreaks of the disease there.

—△—

Doctor Feurig Retires Temporarily

Dr. James S. Feurig withdrew from the Brusky Clinic in Green Bay in August and retired temporarily from active practice. The doctor, a veteran of three and one-half years as a flight surgeon with the Army Air Forces, served in the European, Pacific, and China–Burma–India Theaters until discharged in January, 1946. He is now living in Milwaukee.

—△—

Health Officers Attend Meeting

Meeting at the Viroqua Court House September 6, thirty-two health officers of the town of Viroqua and members of the health board heard the following program presented:

The General Activities of the Local Health Officer—*Arthur L. Van Duser, M. D.*, district health officer.

The Health Officer's Role in the School—W. J. Schallock, county superintendent.

The Health Officer's Responsibility in Regard to Communicable Disease Control—*H. M. Guilford, M. D.*, director, Bureau of Communicable Disease Control, Wisconsin State Board of Health.

Movie—"Tuberculosis."

Hospitalization of Patients to the Wisconsin General Hospital and Tuberculosis Sanatoria —Honorable Lincoln Neprud, Vernon County Judge.

Summary and Discussion.

Those present at the meeting voted in favor of having annual meetings of this sort that would be of value to health officers. No date for the next meeting was set but suggestions were made about a meeting early next summer.

—△—

Chest Physicians Re-elect Wisconsin Doctors

At the annual meeting of the American College of Chest Physicians, held at San Francisco, June 27–30, *Dr. Andrew L. Banyai* of Milwaukee was re-elected regent of the College for district No. 10, which comprises the states of North and South Dakota, Wisconsin, Iowa, Minnesota, and Nebraska. At the same meeting *Dr. Carl O. Schaefer*, Racine, was chosen to succeed himself as governor of the College for the state of Wisconsin.

—△—

Doctor Practices For Quarter Century

Dr. S. O. Lund has completed twenty-five years of medical service to the town of Cumberland. Since his arrival at Cumberland from Montevideo, Minnesota, the doctor has officiated at the birth of 1,357 babies in the area.

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Huron La Crosse Rapid City Rochester Stevens Point Wausau Winona

In 1929, Doctor Lund and *Dr. G. A. Grinde* built the Cumberland Clinic, later adding wings to the Cumberland Hospital and building the nurses' home. A year after Doctor Grinde's death in 1937, *Dr. R. C. Thompson* bought a half interest with Doctor Lund and they run the clinic together today.

In addition to serving the community as general practitioner, Doctor Lund, a 1916 graduate of Rush Medical College, has given time and labor to civic affairs, serving as president of the school board for eight years and for twenty years executing the duties of city health officer.

Doctor Lund comes from a family of doctors. Two of his brothers are physicians and two, dentists. Doctor Lund's three sons are following in their father's footsteps, as two of them already have their degrees in medicine and the third began his pre-medical training at Macalester in St. Paul this fall.

—△—

Oconomowoc Honors Dr. M. R. Wilkinson

Oconomowoc paid tribute to one of its most prominent and honored citizens, *Dr. M. R. Wilkinson*, on September 29, the occasion of his eighty-second birthday. The public program honoring "Dr. M. R.," as he is called, who started practicing medicine in Oconomowoc fifty-three years ago, was held in the city park with Rev. Donald Miller, rector of the Redemptorist Seminary on Lac La Belle, as principal speaker. Among others who gave praise for Doctor Wilkinson's service to the community was *Dr. William James.*

The reception was sponsored by the Edwin L. Jones Post of the American Legion, of which Doctor Wilkinson is a charter member. The Oconomowoc doctor has been active in civic, social, and professional organizations for years, holding offices in the Waukesha County Medical Society and the American Legion local post. He is president of the Waukesha County Historical Society and athletic director of Oconomowoc High School.

Doctor Wilkinson and his wife have three sons who are with the Oconomowoc Clinic, *Drs. J. Francis, John,* and *Donald Wilkinson,* and another son, *Dr. Phillip Wilkinson,* released from military service will join the clinic soon.

SEVENTH ANNUAL DEARHOLT DAY PROGRAM

(Continued from page 968)

Milwaukee, Tuesday, November 19, 1946

p.m.

2:30—Auditorium, Marquette University School of Medicine, 561 North Fifteenth Street.

Presiding—Introductory Remarks: Dr. Eben J. Carey, dean, Marquette University School of Medicine, Milwaukee.

"B. C. G. in Tuberculosis"—Doctor Rosenthal.

"The Cause of Apical Localization of Tuberculosis and its Implications for Treatment"—Doctor Wilson.

p.m.

6:30—Dinner, Members of Milwaukee Academy of Medicine, Wisconsin Trudeau Society, and guests, University Club, 924 East Wells Street.

8:15—Meeting of the Milwaukee Academy of Medicine, Wisconsin Trudeau Society, and guests, University Club.

Presiding—Introductory Remarks: Dr. Frederick W. Madison, president, Milwaukee Academy of Medicine, Milwaukee.

"B. C. G. in Tuberculosis"—Doctor Rosenthal.

"Pulmonary Emphysema: Pathologic Physiology and Treatment"—Doctor Wilson.

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★ BROWN COUNTY ★

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★ JUNEAU COUNTY ★

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★ CHIPPEWA COUNTY ★

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★ KENOSHA COUNTY ★

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★ DOUGLAS COUNTY ★

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★ OUTAGAMIE COUNTY ★

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THE JOURNAL BOOKSHELF

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, S. M. I. Building, Madison, Wis.

Diseases of the Breast. By Charles F. Geschickter, M. A., M. D., Lieutenant Commander, Medical Corps, United States Naval Reserve, Director of The Francis P. Garvan Cancer Research Laboratory, Pathologist, St. Agnes Hospital, Baltimore; with a special section on Treatment in Collaboration with Murray M. Copeland, A. B., M. D., F. A. C. S., Instructor in Surgery, Johns Hopkins Medical School, Visiting Surgeon and Assistant Oncologist, University Hospital, University of Maryland Medical School, Visiting Oncologist, Baltimore City Hospitals. Second Edition. Pp. 826 with 593 illustrations. Philadelphia, London, Montreal: J. B. Lippincott Company, 1945. Price $12.00.

The second edition is a worthy successor to the first edition which was recognized as an outstanding treatise on Diseases of the Breast. The book has been enlarged and some chapters rewritten.

New material has been added so as to cover the most recent advances in diagnosis, pathology, and treatment. Among these are cosmetic considerations concerning under-developed and pendulous breasts, penicillin therapy for infectious mastitis, the criteria of operability and inoperability of mammary carcinoma, the relative merits of surgery and irradiation for this condition, the endocrine therapy of chronic cystic mastitis, and the etiology of mammary carcinoma.

The chapter on experimental production of benign and malignant mammary tumors reviews the experimental evidence which helps to understand rational therapy. This book is a most important contribution. Needless to say, it has to be read for the intelligent management of diseases of the breast. E. R. S.

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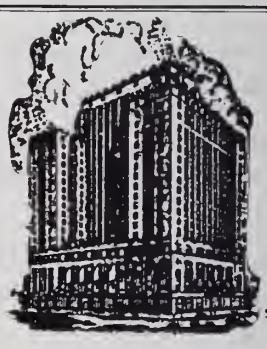

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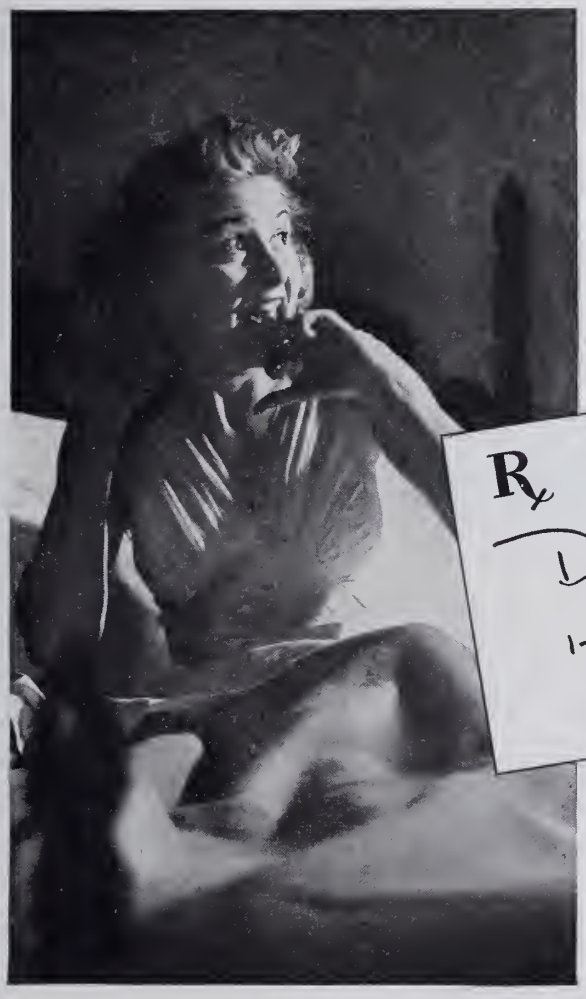

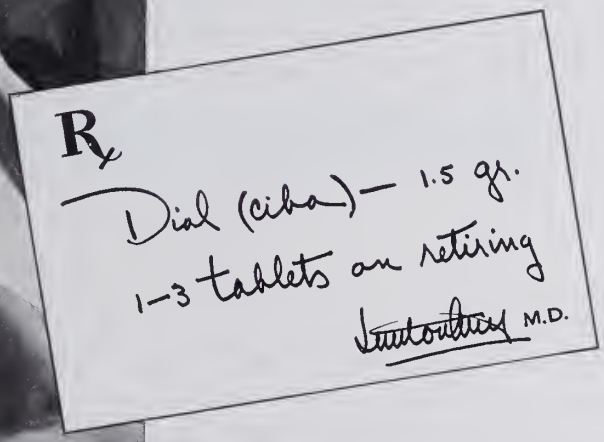

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Frazer* states that the ordinary mode of effecting the cure is to split a young ash sapling longitudinally for a few feet and pass the child, naked, either three times or three times three through the fissure at sunrise. In the West of England, it is said the passage must be "against the sun." As soon as the ceremony is performed, the tree is bound tightly up and the fissure plastered over with mud or clay. The belief is that just as the cleft in the tree will be healed, so the child's body will be healed, but that if the rift in the tree remains open, the deformity in the child will remain, too, and if the tree were to die, the death of the child would surely follow.

*Frazer, J. G.: The Golden Bough, vol. 1, New York, Macmillan & Co., 1923

It is ironical that the practice of attempting to cure rickets by holding the child in the cleft of an ash tree was associated with the rising of the sun, the light of which we now know is in itself one of Nature's specifics.

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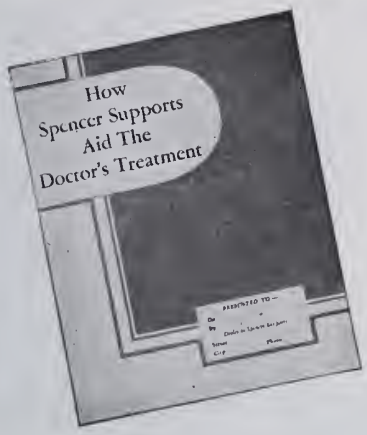
1. Lennox, W. G. (1945), Petit Mal Epilepsies: Their Treatment with Tridione, J. Amer. Med. Assn., 129:1069, December 15.
2. DeJong, R. N. (1946), Effect of Tridione in the Control of Psychomotor Attacks, J. Amer. Med. Assn., 130:565, March 2.



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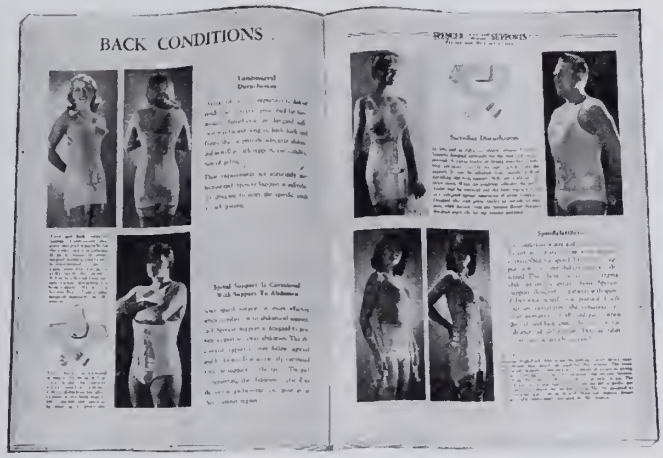

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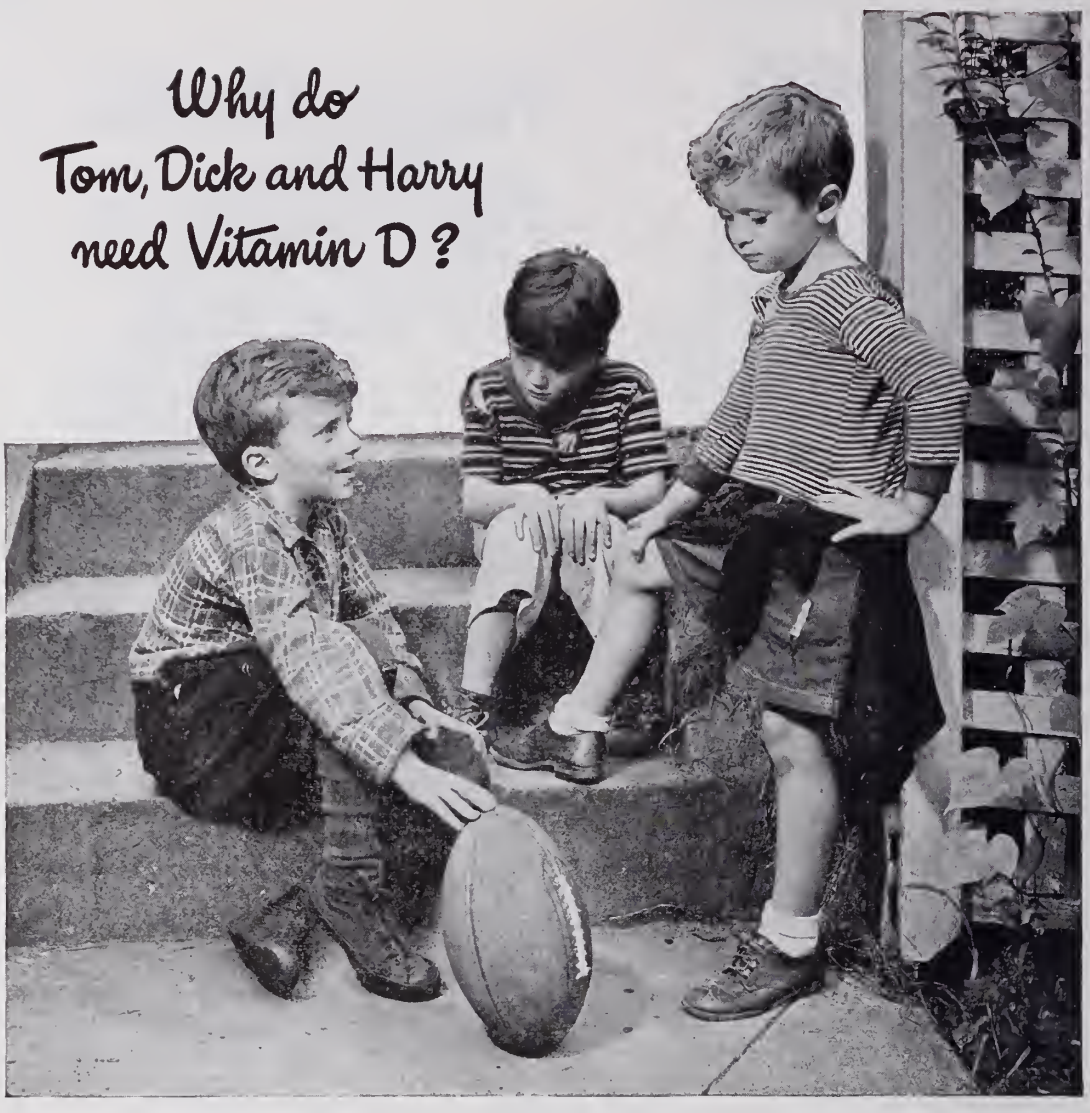

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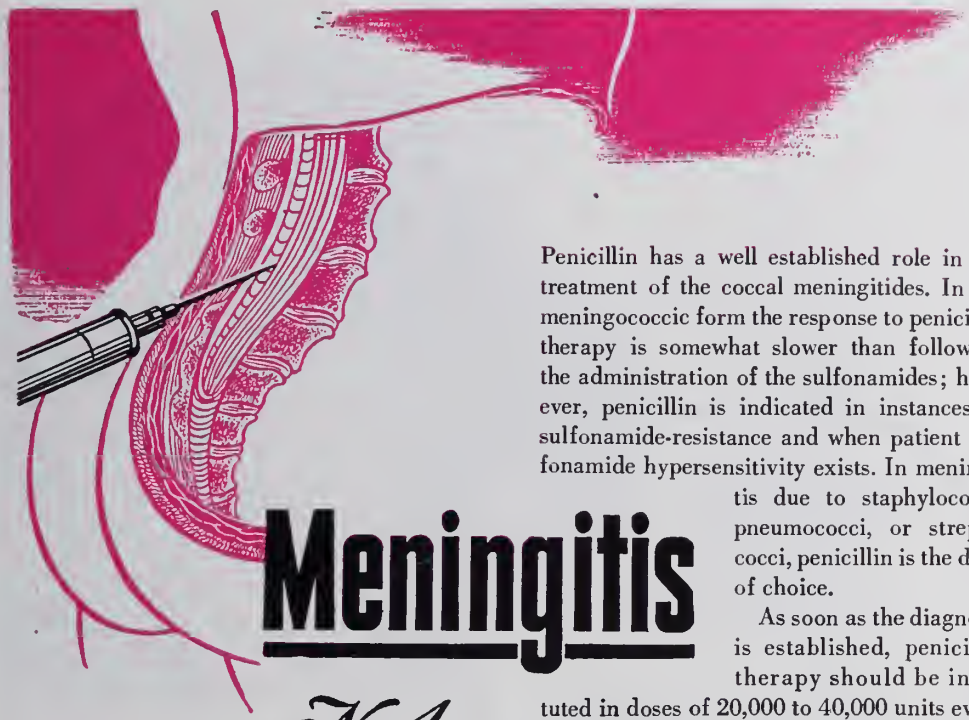

Meningitis

No. 4

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As soon as the diagnosis is established, penicillin therapy should be instituted in doses of 20,000 to 40,000 units every two to three hours by the intramuscular route. Treatment should be thorough, and should be continued until all signs and symptoms of the infection have been absent for seven to ten days. Since penicillin administered systemically does not penetrate the subarachnoid space, intrathecal (intraspinal, intracisternal, intraventricular) administration is also required. Ten thousand units in 10 cc. of isotonic solution of sodium chloride should be injected (after withdrawal of an equal volume of fluid) once or twice daily until the spinal fluid is clear, and for four days thereafter.

When concurrent sulfonamides are indicated, they should be administered in a dosage sufficient to establish a blood level of 15 mg. per cent.

Surgical, supportive, and other measures should be employed when indicated.

SPINK, W. W., *and* HALL, W. H.: *Penicillin Therapy at the University of Minnesota Hospitals: 1942-1944, Ann. Int. Med. 22:510 (April) 1945.*

WHITE, W. L.; MURPHY, F. D.; LOCKWOOD, J. S., *and* FLIPPIN, H. F.: *Penicillin in the Treatment of Pneumococcal, Meningococcal, Streptococcal, and Stophylococcal Meningitis, Am. J. Med. Sc. 210:1 (July) 1945.*

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REFERENCES: 1. Cornbleet, T. and Pace, E. R.: Arch. Derm. & Syph., 31:224, 1935. 2. Hansen, A. E.: Am. J. Dis. Child., 63:933, 1937. 3. Taub, S. J. and Zakon, S. J.: J. A. M. A., 105:1675, 1935. 4. Stoesser, A. V.: Ann. Allergy, 2:404, 1944.

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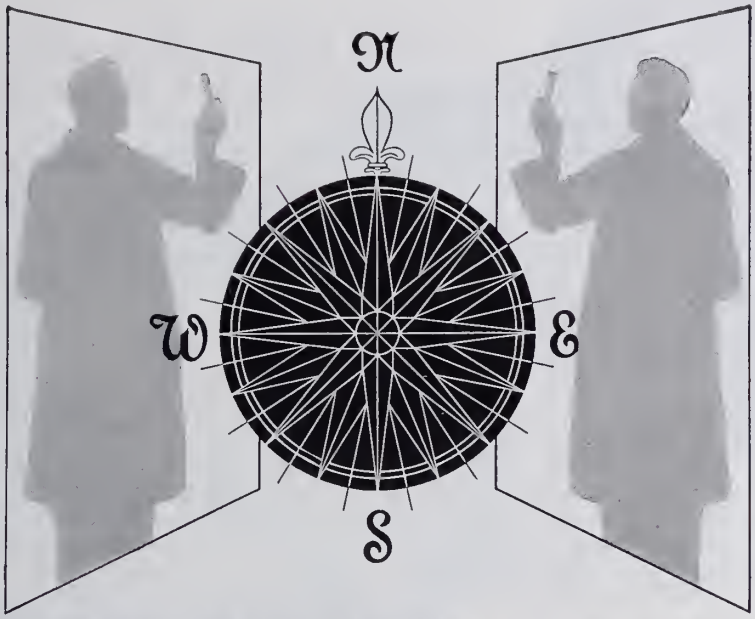

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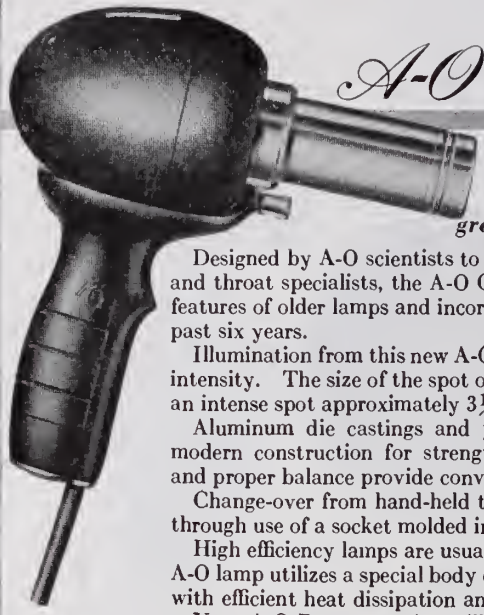

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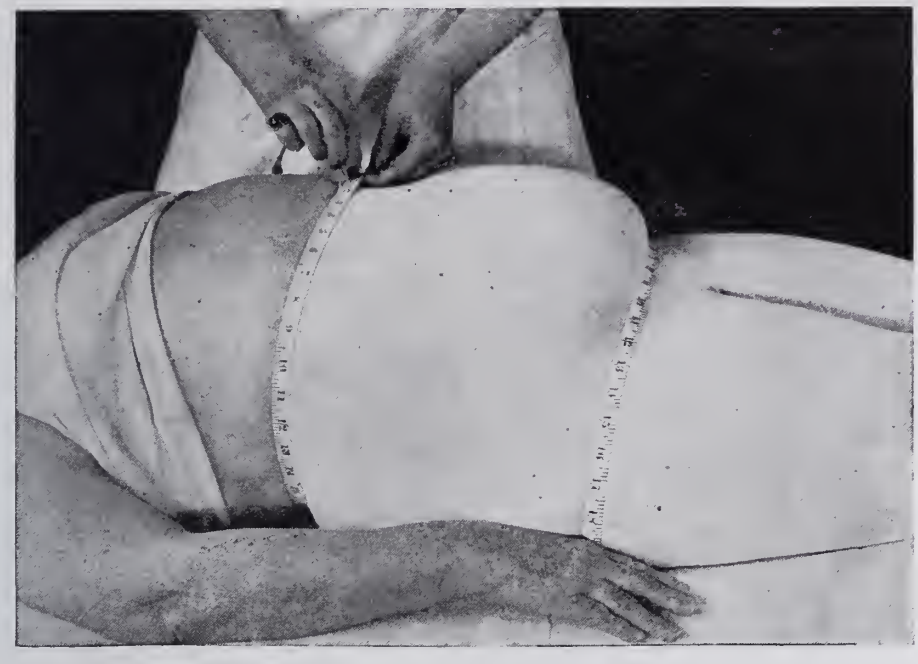

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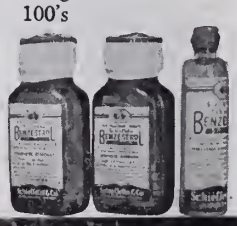

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WANTED: Assistant for busy general practice including considerable surgery and obstetrics, preferably a young physician; northern Wisconsin city of about 50,000. Include credentials and photograph; salary open; percentage. Wonderful opportunity for the right man. Address replies to No. 53 in care of the Journal.

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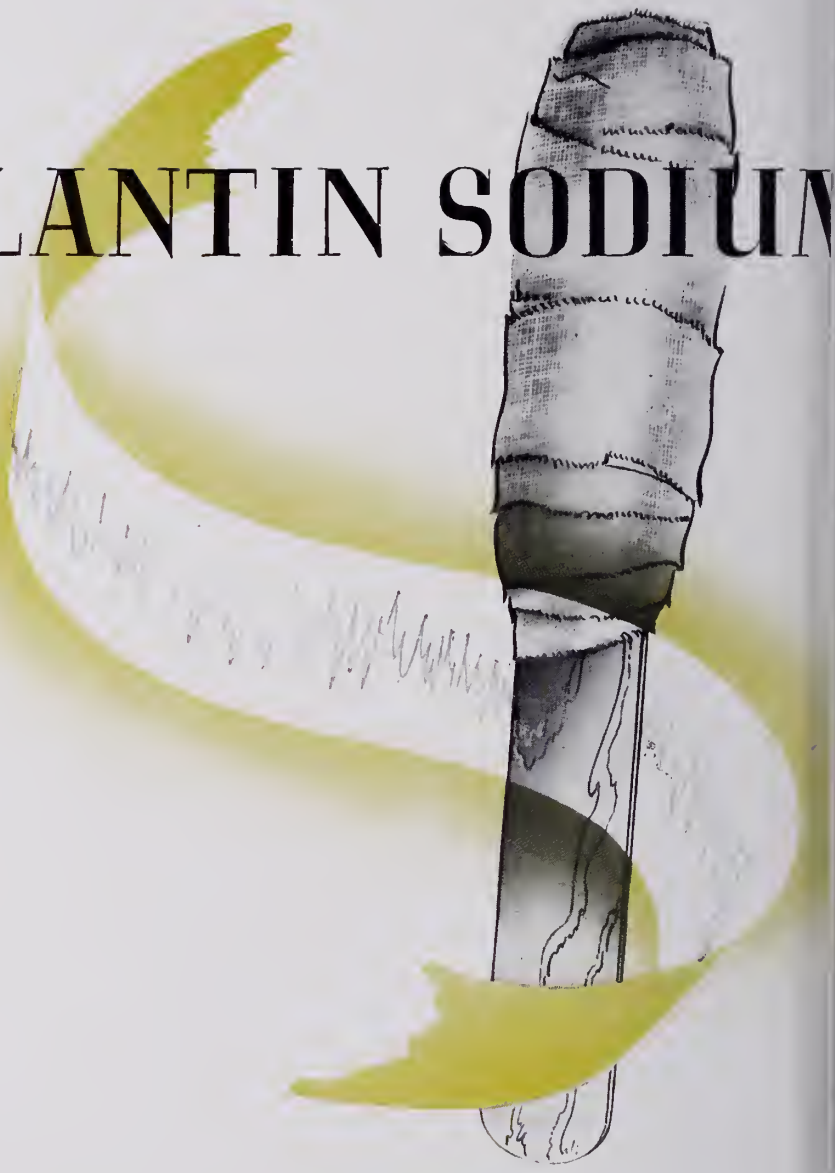

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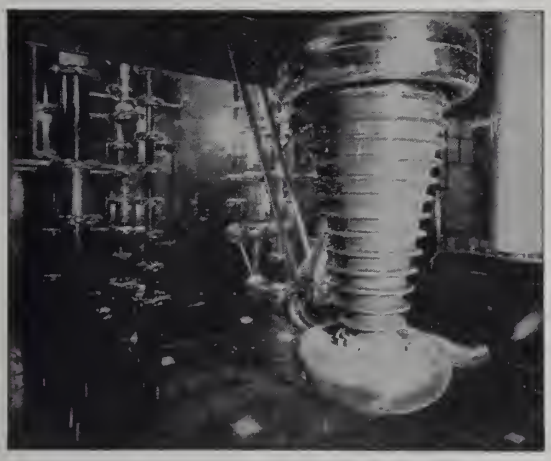

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• •

1. Gold, H.: Connecticut M. J. 9:3 (Mar.) 1945.
2. Levine, Samuel A.: Clinical Heart Disease, ed. 3, Philadelphia, W. B. Saunders Company, 1945, p. 273.
3. Gold, H.; Kwit, N. T.; Cattell, M., and Travell, J.: J.A.M.A. *119*-928 (July 18) 1942.
4. Gold, H.; Cattell, M.; Modell, W.; Kwit, N. T.; Kramer, M. L., and Zahm, W.: J. Pharmacol. & Exper. Therap. *82*:187 (Oct.) 1944.

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1. Montgomery, J. B.: M. Clin. North America 29:205 (Nov.) 1945.

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*R. H. Follis, D. Jackson, M. M. Eliot, and E. A. Park: Prevalence of rickets in children between two and fourteen years of age, Am. J. Dis. Child. 66:1-11, July 1943.

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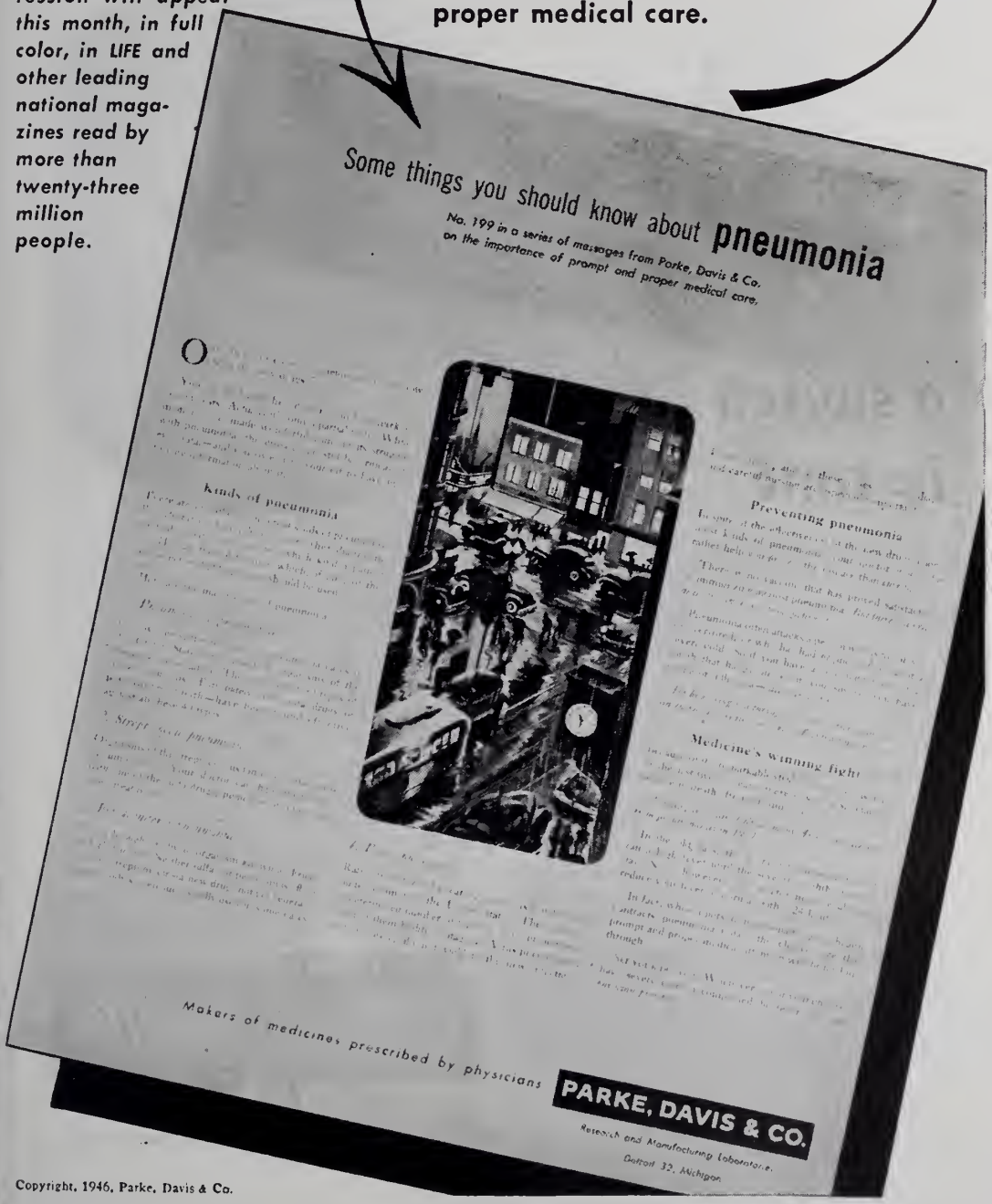

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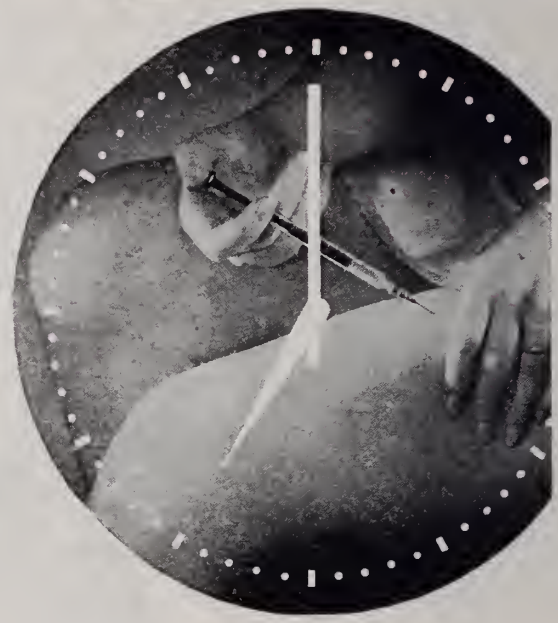

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*Stare, F. J., and Thorn, G. W.: Protein Nutrition in Problems of Medical Interest, J. A. M. A. *127*:1120 (April 28) 1945.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

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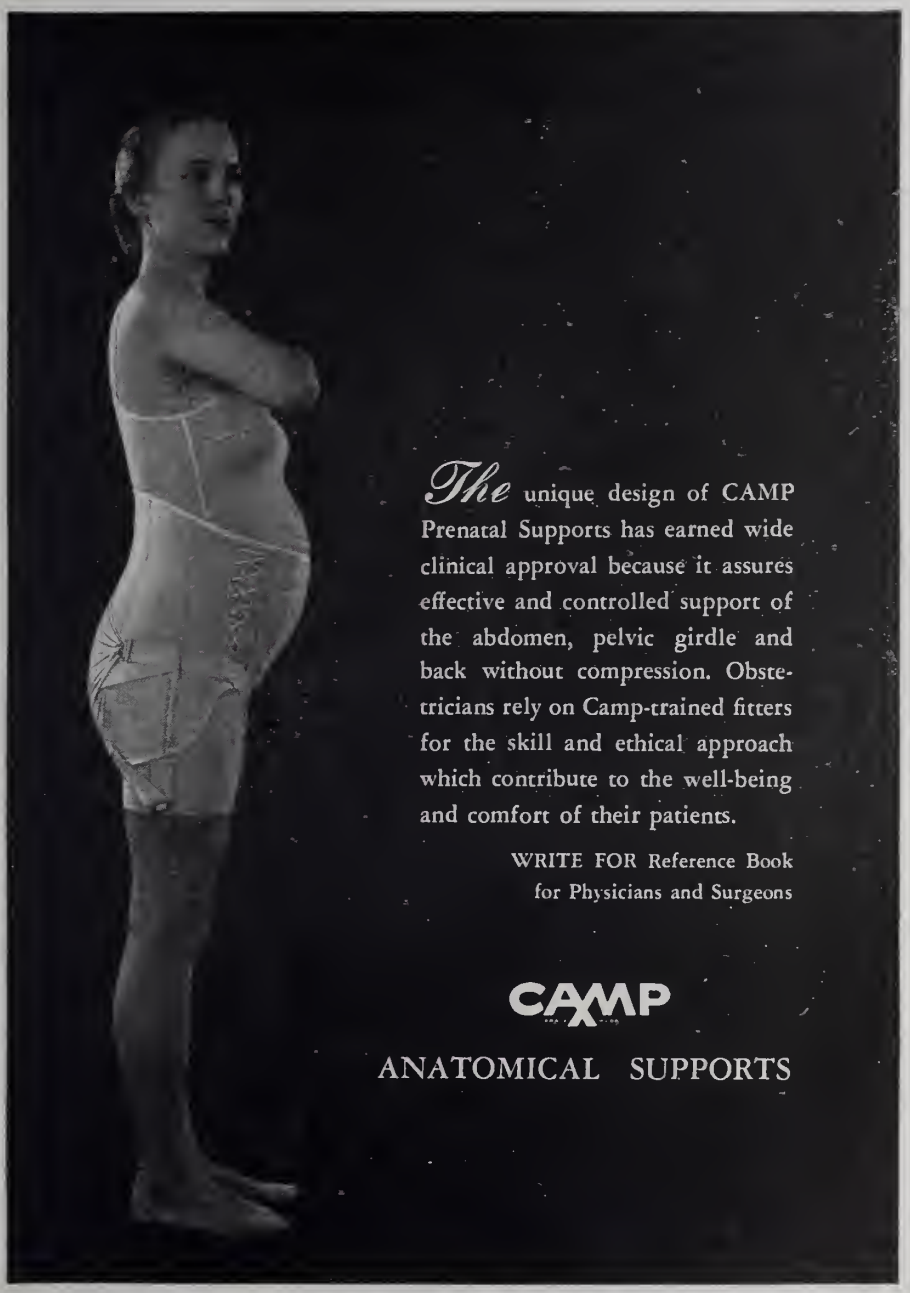

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The centuries fall like grains of sand
We meet today, united, free,
And loyal to our land and Thee,
To thank Thee for the era done,
And trust Thee for the opening one.

Whittier

THE
MEDICAL PROTECTIVE COMPANY
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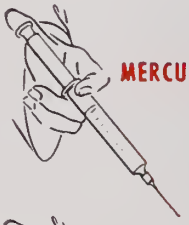
to protect the decompensated heart



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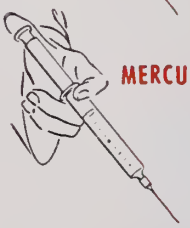

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40 CALORIES (APPROX.)		20 CALORIES PER OZ. (APPROX.)

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1 FLUID OUNCE	1½ OUNCES	2½ FLUID OUNCES
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LIQUID, containing 0.625 mg. per 4 cc.

conjugated estrogens (equine)

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Bad winter ahead for the pneumococci

STORMY DAYS are usually followed by sharp increases in the incidence of upper respiratory infections, often the prelude to pneumococcal pneumonia. Fortunately, physicians are prepared to combat the pneumococci with sulfonamides and penicillin.

Although sulfonamides are generally effective, problems sometimes arise in their administration. In the patient with cardiac or renal disease, it may be difficult to maintain proper fluid balance. This imbalance may lead to urinary tract complications. Others may experience untoward toxic effects or lack of response to the drug. In these cases, Penicillin, Lilly, is particularly valuable. While the intramuscular injection of 10 to 15 thousand units every three hours throughout the night and day might be helpful, doses of 20 thousand or more units at the same intervals are preferable. Penicillin, Lilly, is available in 20-cc. ampoules containing 100,000, 200,000, or 500,000 units.

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THE WISCONSIN MEDICAL JOURNAL

VOLUME 45, NO. 11 Copyright, 1946, by The State Medical Society of Wisconsin NOVEMBER, 1946

Is Overspecialization a Threat?

By C. A. DAWSON, M. D.
River Falls

A FORTNIGHT ago there came to my desk a letter from a physician friend who lives in St. Paul, and who is a diplomate of a specialty board. The writer of the letter said, "You probably have already become aware of this organization of medical men. If you have not, I feel that it should be brought to your attention. Although I am, as you know, a diplomate of a specialty board, I cannot but feel sympathetic to the movement." There was enclosed with the letter the Constitution and By-laws of a new organization of medical men, The American College of Physicians and Surgeons. I would like to read Article II of its Articles of Incorporation, and I quote: "The general purpose of this corporation is to provide an organization for the maintenance and betterment of service to patients and for the betterment of the scientific, economic and social standing of its members among their colleagues and patients. To that end the corporation shall operate upon the premises (1) that all duly licensed physicians and surgeons are professionally honest until proved otherwise, and scientifically equipped to undertake the practice in which they are engaged, and have equal rights, privileges and responsibilities in the practice of their profession, (2) that no special interest group shall have the right to control or hamper the practice of any duly licensed physician or surgeon according to his judgment or to dictate or influence the treatment or the disposal of his patients or to deny him or his patients access upon an equal basis to the physical facilities necessary or convenient to his practice and the treatment of his patients, and (3) that no political group by political means shall control the economic, social or scientific status of any duly licensed physician or surgeon."

Article IV of the same document in delineating requirements for membership says in part, and I again quote: "Membership in any of the specialist boards, colleges or similar organizations of physicians and surgeons, the rules and regulations of which require its members substantially to limit their practice to a particular field or fields, shall disqualify any person from membership in this organization."

Being interested in the effect upon medicine of so-called over-specialization I inquired of the Minnesota State Medical Association as to the type and standing of the several physicians who were named as incorporators. The information received was to the effect that they were all ethically and professionally men of the highest qualifications. At the cordial and urgent request of their president, Dr. Claude Kennedy, I later attended a meeting of the organization in the auditorium of the Hennepin County Medical Society. There I found a body of outstanding physicians and surgeons—men who were attempting to solve a question that is today causing wrinkles in the brows of both specialist board diplomates and general practitioners—men who are very apparently not so much interested in the matters involved from a selfish standpoint, but rather, interested in the welfare of medicine of the future. Whether they have found what will eventually be the answer or not I shall not presume to predict.

Reasons For Specialization

In so far as Wisconsin is concerned, interesting information has been developed during the past year at the several sessions of the State Board of Medical Examiners. For the convenience of medical men returning from the armed services and desiring to practice in this state, six meetings of the board have been held this calendar year. All of the applicants have been asked questions as to what type of medicine they expected to practice. Practically 10 per cent signified their intentions to practice general medicine. The 90 per cent intended to be anesthesiologists, orthopedic surgeons, obstetricians, or specialists in some other of the specialist fields. In private talks with many of these young men the reasons which they gave as influencing them in their decisions were as follows:

1. That they had been assigned to specialized service under a specialist in one certain field and had become impressed by the type of work that had been done by that individual. Having had some experience and training along that line they felt that they should not waste the knowledge that they had thus acquired.

* Presidential Address presented at the One Hundred Fifth Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1946.

2. That there was much more opportunity for large financial gain in the specialist fields than in the field of general medicine.

3. That in the specialist fields the work was not so arduous—that night work was seldom necessary (except in the field of obstetrics), and that, with their work being almost entirely hospital and office work, much more time could be devoted to cultural advancement and to social and recreational pursuits.

4. That there is an increasing tendency on the part of hospitals to limit their staffs to specialist board rated men. These men pointed out that without specialty rating they would have little or no possibility of being able to hospitalize their patients under their own service and administer to them their own treatment. It was the thought of these men that as time passed the opportunity for general practitioners to obtain staff appointments would become more and more difficult. In certain cities and in certain excellent institutions this condition has indeed become fact. No argument can controvert the fact that the general practitioner, for instance, who is forced to turn his obstetric cases over to an obstetrician for delivery and the new born babe to a pediatrician in order for them to get hospital care, is being handicapped.

5. One more reason that the young man looks askance at the general practice of medicine is that, in his opinion, the prestige of the specialist is steadily mounting while that of the general practitioner is suffering a corresponding decline.

All of these reasons seem important to young men, and, indeed they are. Theirs is the task of mapping out their future. They hesitate to hitch their wagons to a falling star. Advice is as varied as the number of their advisors.

Dearth of General Practitioners

During the past four years the need for medical men throughout the state of Wisconsin has been increasing to a well-nigh alarming degree. Especially has this been true in the outlying districts. Many of our confreres who had retired have again taken up the burden of the practice of medicine—this, for no other reason than that they recognized their duty to humanity. These men are tired. Many of them want to again lay down their burdens. Many of the older men want assistants. Some localities are practically without medical care. During the past year alone the State Board of Medical Examiners has signed reciprocity papers for men who are applying for licensure in other states to the number of 129. Wisconsin, even outside the highly congested districts, could profitably absorb many general practitioners. Under the present trend there appears little promise of relief.

Divergence of Opinions

If one wades through the volumes of written opinions on this subject he comes out bewildered and realizes full well that here is a problem to solve. He finds at one end of the gamut an extreme opinion written as follows: "It may be the case that one who has spent a long apprenticeship in more than one specialty may be able to combine excellent knowledge on more than one subject and thus qualify for general work. But it is to me only a sign of the still backward state of medicine that we should regard general medicine or surgery as in itself the most admirable thing, for it ought, as years pass, TO EFFACE ITSELF, and, in the meantime, TO BE APOLOGETIC FOR ITS EXISTENCE. We do not appear to be sufficiently far advanced to get rid as yet of an anachronistic system, although we have the knowledge to correct it."

On the other end of the gamut we find many expressions of opinions such as the following: "Not a few of those who have thought much on the subject and kept a wary eye on trends of the past two-score years believe that the only way for general practice to survive is for it to be upheld in the public esteem—given its due by those doing a more glamorous practice. And of a certainty, were general practice to be destroyed, the whole superstructure of specialism would go down in a mighty crash." And again: "It looks to the general practitioner as though the limits of specialization desirable for our time are approached, if, indeed, they have not actually reached or even transcended them; for it is feared that increased restrictions in the field of work will multiply progressively the dangers from specialization with the consequent loss of its advantages."

Problem

Medicine today is in a vortex which has been created by its own progress. As the profession becomes more and more exact, specialism becomes more and more necessary and it becomes more and more difficult for the patient to obtain comprehensive medical care. When specialism has developed to the point where the whole man is being treated by different types of specialists who have little or no common ground upon which to stand, specialism will have become a dangerous thing. No one would decry the necessity for specialized knowledge, but some way must be found to integrate specialism into comprehensive medical care.

Today the goose hangs high. Everyone's pocket is bulging with money. People seek the glamorous side of medicine. They are able to stand the expense of high cost medical and surgical care. When the next recession comes, the office space of many of the young specialists may be for rent, and the specialists may be seeking positions as medical technicians, or what not. The problem is one that concerns all of medicine. The causes, in relation to the effect, should be studied, and the solution, or solutions, discovered. No one man will find the answer.

Trends and Progress in Neuropsychiatry*

By HANS H. REESE, M. D.
Madison

H. H. REESE

Doctor Reese, a 1918 graduate of the University of Kiel in Germany, is professor of neuropsychiatry at the University of Wisconsin Medical School and research assistant of the Wisconsin Psychiatric Institute, Madison.

Among the medical societies in which the doctor holds positions are: fellow of the American Medical Association; director, American Board of Psychiatry and Neurology; fellow of the American College of Physicians, and the American Neurological Association.

THE content of this article presents the question of whether one physician can be a specialist in both neurology and psychiatry, considering the recent advances in neuro-anatomy, neurophysiology, and psychologic medicine. In my opinion neurology and psychiatry must remain in essence distinct, as each specialty covers individual fields so intensively that a single individual cannot be an expert in both. However, the neurologist of the future must possess a better knowledge of psychiatry and psychopathology, and the psychiatrists of the future must master medical psychology and know more of clinical neurology.

Psychosomatic medicine, as a specialty, is Utopia for even a Hercules. Its object is to study, in their interrelation, the psychologic and physiologic aspects of all normal and abnormal bodily functions, thus integrating somatic medicine and psychotherapy. George Draper, the outstanding proponent of psychosomatic medicine, changed our attitudes toward physical illness and stressed the emotional factors in disease. Thus the concern of psychosomatic medicine is with the emotional factors in physical diseases, which in my opinion should be known to every competent general physician. There is no dualism between mind and body. To use Adolf Meyer's words: "What is of importance to us is the activity and behavior of the total organism or individual in health and disease as opposed to the activity of single detachable organs." Every disease is psychosomatic and all vital functions are continually influenced by the emotional or mental state of the individual. At the end of my paper you may decide if a neuropsychiatrist has a place in medicine as a kind of "hybrid" specialist.

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NEUROLOGY

Meningitis

The problem of meningitis is no longer baffling, with serum, sulfa drugs, and penicillin at our disposal. The specific etiology must be established at once and the individual dosages for the various drugs must be worked out in each case. A blood level of at least 10 to 15 mg. and a spinal fluid level of 7 to 10 mg. must be built up quickly by initial intravenous loading doses in sulfa therapy. Depending upon the clinical response or failure, penicillin by the continuous intramuscular drip method, "type specific" serum or antitoxin must be added. I do not believe in the intrathecal routine medication of penicillin or serum and question the statement in the literature that early intraventricular or intrathecal treatment prevents leptomeningeal adhesions and liquor pocketing. Mechanical procedures in the form of punctures at various levels with air inflations are often necessary to break up adhesions.

Encephalitis

The virus infections of the cerebrospinal axis, the demyelinating disorders (especially the multiple sclerosis and even poliomyelitis) remain unanswered questions to our specific therapeutic efforts. The classification of the demyelinating diseases cannot be carried out satisfactorily because so little is known about their etiology. In the present state of our ignorance we group demyelinating diseases according to clinical and pathologic features. Therefore, controversial discussions concerning the varieties of diffuse sclerosis or the relationship between acute disseminated encephalomyelitis and acute disseminated sclerosis and neuromyelitis optica is mainly with words. The forms of acute disseminated encephalomyelitis which follow a known predisposing cause such as measles, small pox, vaccination, or antirabic inoculation, suggest that the encephalomyelitis is due to the virus of the primary infection. However, the allergic or hyperergic theories assume that the nervous system has become in some way sensitized to the virus which explains the similar pathologic reactions to different viruses. Neuro-allergy is an interesting and important field of research about which we talk much but know very little.

Neurosyphilis

A few words suffice to explain the present status of treatment of syphilis of the central nervous system. In neurosyphilis, penicillin is not fulfilling its expectation, and at present I would state that peni-

cillin is not an efficacious drug in our antiluetic therapeutic armamentarium. Malaria, or fever treatment, in combination with mapharsen, tryparsamide, bismuth, and iodides are superior and "cure" the meningeal and parenchymatous types. We have not been able to alter the Wassermann serology of central nervous system syphilis with large, continuous, and repeated medication of penicillin, although a certain amount of physical well-being has been obtained in some patients.

Myopathies

The pathologic physiology of denervated muscles with the most obvious and interrelated features of degeneration such as atrophy, fibrillation, and changes in chemical or electrical excitability remains fixed in the literature on the destruction of contractile elements, on the absence of vascular conditioned rhythmic muscular contractions, and on disturbances of the neuromuscular transmitter or end-plates. Dean Carey's micropressure wave mechanism in striated muscles with its clear photomicrographic evidence disproved the sarcomere theory of Krause. Carey's anisotropic contraction nodes, the isotropic internodes with nuclear alterations upon cytoplasmic pressure or metabolic changes, have as yet, not sufficiently aroused the clinical investigator. Muscle is not a fixed unit of anatomic or myotomic structure. Its metabolism is never static. Electromyographic studies prove these statements. Creatine and creatinine, proteolytic and tryptolytic enzymes, calcium, phosphorus, potassium studies, the vitamins or oxidation researches have not benefited the sufferers from muscular atrophies or dystrophies nor have they established a possible etiology of myodeficiency. Myotonias (quinine) and myasthenias (prostigmine) can be controlled in their clinical symptomology but the etiology of the disease process remains obscure. All patients with myasthenia gravis should be subjected to x-ray studies in an effort to diagnose thymic involvement early, so that irradiation and surgical removal could be essayed in the treatment. The neuritic symptoms in the muscular disorders are commonly relieved by the whole vitamin B complex, but the more specific muscular symptoms respond better to wheat germ oil. The possible relations of vitamin E to muscle protein metabolism, to the hypothalamus and pituitary gland remain controversial. Vitamin E (tocopherol acetate or ephynal acetate) plus vitamin B is often an ameliorator of amyotrophic lateral sclerosis. Muscle studies have been neglected in the past and the general statements of orthodox muscle physiology and pathology cannot be accepted today.

Vascular Hypertension

The problem of vascular hypertension has filled many tomes and the various theories are known to all. The degree of sclerosis visualized in a characteristic retinal pattern (arteries narrowed and sclerotic, arteriovenous nicking, flame-shaped hemorrhages, cotton wool exudate, and edema of the discs) mirrors in most instances, especially in advanced or malignant cases, that found in cerebral or peripheral arteries. Edema of the optic discs in malignant hypertension, however, does not denote increased intracranial pressure as measured by an increased cerebrospinal fluid pressure. Since the thickness of the walls of cerebral arterioles reduces the caliber of the lumen, it thus interferes with regional or general parenchymal nutrition. The common cerebral lesions responsible for clinical symptoms are: (1) intracerebral and extracerebral edema, (2) spasm with small areas of softening, (3) multiple miliary destructive lesions such as hemorrhages, infarcts, and (4) large destructive lesions. The symptoms of (1) and (2) can be ameliorated by mechanical dehydration procedures, by vasodilators, fluid restriction and diet. The spontaneous intracerebral hemorrhage with a resemblance to the neoplastic syndrome should be surgically explored through a burr hole with aspiration of the blood and may be often the life-saving intervention in comatose apoplexy.

The surgical treatment of hypertension is without doubt one of the greatest accomplishments to alleviate the afflicted ones and to control by this surgical procedure irreparable damages. The selection of cases for this surgery on the sympathetic nervous system requires: (1) an age limit of preferably not over 50, (2) adequate renal function as indicated by a urea clearance of more than 40 per cent of normal, and a urine concentration above 1,012, and (3) cardiac compensation and an adequate physical status to withstand surgery. Smithwick's recommended surgery is a bilateral transdiaphragmatic removal of the lower dorsal and the upper lumbar sympathetic chain with its ganglions and the rami forming the splanchnic nerves. Peet's operative procedures of bilateral supradiaphragmatic splanchnicectomy and lower dorsal sympathetic ganglionectomy has given excellent results. The effects of the surgical intervention are not temporary and should be recommended in early hypertension and in cases approaching the clinical criteria for malignant hypertension. Not only do the suggestive symptoms of hypertension disappear, but the surgery returns the blood pressure to an accepted nondangerous level. It improves the renal functions and arrests cardiac damage. The surgery on the nervous system in the form of cervicothoracic sympathectomy is most advisable in acrocyanosis, in early Raynaud's disease, and in those severe vascular spasm cases of the extremities.

Headaches

Headaches are caused by dilation of and by traction or displacements on pain-sensitive intracranial vascular structures especially the dural sinuses, the middle meningeal and the middle cerebral arteries or by direct pressure of neoplasms on cranial or peripheral nerves containing many afferent pain

fibers from the head. As an aid in localization, headache is limited by the facts that supratentorial irritations of pain-sensitive intracranial structures are expressed vaguely as pain in front of a line drawn vertically from the ears across the top of the head, whereas infratentorial irritations of those structures of greater intensity are localized behind this line. Pathways for the former are contained in the fifth cranial nerve, for the latter in the ninth and tenth cranial nerves and in the three upper cervical nerves (the "pain in neck syndrome" of fourth ventricle tumors.)

The headache for the physician remains the migraine patient with his familial disposition. During an attack there is painful distention or dilatation of branches of the external carotid artery especially visible in the ipsilateral superficial temperal artery. Ergotamine tartrate produces vasoconstriction and reduces the amplitude and rate of pulsation in the branches of the external carotid artery by some 50 per cent; the rate of diminished pulsation amplitude parallels the gradual reduction of painful hemicrania. A new Sandoz preparation D. H. E. 45 has eliminated the side effects of nausea, vomiting, and muscle pain of ergotamine tartrate and makes it a less hazardous drug for possible ergotism.

Histamine headache is an allergic congestive phenomenon about the meningeal arterial tissues and is due to the thrust of heightened arterial pressure upon dilated cerebral vessels, stretching of which causes pain. The diagnosis is established by intracutaneous testing with subsequent desensitization.

The dual mechanism of Ménière's syndrome is caused either by a primary vasodilation with overproduction of endolymph and function interference of cochlea and vestibule, or by the much more common primary vasoconstriction—a spasm—with temporary anoxia of cochlea and vestibule. Surgical division of the vestibular nerve is no more the final answer to treatment than is nicotinic acid, potassium chloride, salt-free diet or histamine.

Tumor Diagnosis

The diagnostic methods in intracranial and spinal tumors have facilitated an early detection of neoplasms. Radiography focuses attention on bone abnormalities, on calcification in the tumor, and on displacement of the pineal body. Pneumo-encephalography or ventriculography informs us of the contours of the subarachnoid space, the size, shape, position and patency of the ventricular silhouette, and of the nature and extension of the tumor. Arterial encephalography with thorotrast—really a cerebral angiography—renders the blood vessels of the anterior and middle cerebral arteries visible and permits differentiation of highly vascular tumors (glioblastoma) from meningiomas, aneurysm, angiomata, and vascular degenerative disorders. Electro-encephalography which records the normal and abnormal electrical activity in the brain of living beings, was introduced by Hans Berger in 1924 as a diagnostic clinical method. It has since opened up a vast field for investigation in neurophysiology and in clinical problems. The electroencephalograph lends itself especially to the study of cortical responses to various forms of sensory stimuli or irritations.

Epilepsies

Abnormality of the brain waves and disordered rhythm of brain potentials have given us new facts about epilepsy, so that the classifying diagnosis of epileptic seizure type often can be made. In grand mal the normal frequency of the brain potentials of 8 to 20 waves a second increases to 25 to 30 a second and appears as sharp spikes; in petit mal, quick, sharp spikes and slow, round waves of 3 a second alternate, whereas in psychomotor attacks the slow rate of 3 to 4 a second has predominantly square, notched, flat-topped waves. The clinical observation remains however paramount, since the forms of clinical seizures cannot be predicted accurately from the electro-encephalogram, Gibbs and Lennox have obtained extremely interesting facts from the study of relatives of epileptics with this method, and state that abnormal records were found in 60 per cent of the relatives of epileptics, of whom 24 per cent were themselves epileptic, with only 10 per cent in a control group with no history of seizures. In our country the incidence of epilepsies is one-half per cent of the population—epileptics occupy about 10 per cent of the 500,000 hospital beds devoted to neuropsychiatric disease. Lennox states: If a person with epilepsy will choose a mate who has a normal brain rhythm his chances of having offspring with epilepsy is greatly reduced. His chances of normal offspring are greater than those of parents both of whom have no present or family abnormality but have brain waves of abnormal frequency.

Problem children, behavior disorders, aggressive psychopathic personalities, and mental disorders present in a high percentage paroxysmal cerebral dysrhythmias, therefore the type of the wave and rhythm pattern should direct a selective drug therapy as an adjunct to the guidance program in such cases.

The therapy of epilepsy incorporates many problems. On the physical side, we must map out a specific program which includes hygiene, nutrition, work, and play. I concur with Peterman's opinion, that ketogenic diet tends to alter the physicochemical state or the metabolic activity of the body, favorably correcting the underlying disturbances of brain cell physiology in epilepsy. Ketogenic diet is effective in petit mal epilepsy as attested clinically and by the electro-encephalographic record. The drug schedule should never be static. Bromides, phenobarbital, mebaral, sodium diphenyl hydantoinate = dilantin alone or in combination must be adjusted in the individual case from time to time. The petit mal seizures occur predominantly in patients under the age of 20 years, more likely in

the early hours of the day and upon emotional excitement without an aura or post seizure after-symptoms. This type, the myoclonic flexor jerks and the akinetic epilepsy, with sudden loss of postural control and collapse for seconds or minutes, have been refractive to drugs, but have been benefited by ketogenic diet, by benzedrine or caffeine, and by glutamic acid. The newest drug tridione, a non-sporific drug, offers "a cure" for petit mal and like seizures but is commonly ineffective for grand mal seizures.

Psychiatry

The principles and practices of psychiatry are no more esoteric and unfathomable than any other branch of our profession. Psychiatry is a dynamic science, no longer a step-child of internal medicine and not confined anymore to the walls of state institutions unfortunately commonly called "insane asylums." The incidence of mental illness in civilian life is such that one out of every 22 persons will at some time be hospitalized because of psychoneurotic or psychotic illness. Psychiatry is, in over 75 per cent, an extramural practice of medicine, since intertwining of psychologic and medical symptomatology is much in favor of the former. We know from the daily visitors to your offices without organic structural pathology or physical signs, that well over 50 per cent suffer from functional disorders. In these patients are non-visible forces, i.e., psychologic factors at work, which disturb their relationship to the world in which they have to live and work. They need understanding, recognition, and alleviation. The constitutional and intellectual endowments with modifications by environmental experiences, the biological emotional forces: love, fear, hate, and such social drives as religion, social standards and moral conscience—all these mold our personality, motivate our behavior and symbolic reactions into patterns of integrated dynamic harmony, so that we adjust to situations from within or without in a well-balanced fashion. The goal of psychiatric investigation is to find not only by cooperative searching the etiologic factors of motivational conflicts, which are often unknown to the patient, but at the same time to eject or eliminate by encouragement, by explanation, the underlying mechanisms of his illness and to assist in reorganizing life, behavior, and attitudes. Since this effort is tedious and impossible without the patient's cooperation and confidential relationship, it is neglected by the profession in many intractable, discouraging cases. Psychiatry of today means that the static concepts of personality structure have been replaced by operational analyses of the total personality function. The psychiatric terminology must become consistent with the language of other medical sciences.

Adolf Meyer's Psychobiology emphasizes with the prefix psycho "the devotion to the reactions of the unitary organism in the study of man as a person, clearly within the general framework of biology," and illustrates "the essential elements of full-fledged mentally integrated activity of the total organism." Therefore, the organismal nature of native assets, of instinctual drives, of acquired skills and habits, and of basic variability in moods, imagination, and reasoning, is unfolded as a modification of constitutional structural inheritance through growth (biology,) by various situational life experience factors (psychology,) or by the integrating forebrain hemispheres (anatomy-physiology.) When Meyer then replaced purely hypothetical, "behind the scenes" etiologic factors in psychiatry by his formulation of psychopathologic disorders as an experiment of nature in which the genetic dynamic considerations described the factors favoring or obstructing parergastic or thymergastic modifications upon exogenic, organogenic, neurogenic, psychogenic, and constitutional causes, Meyer opened the doors of the psychiatric workshops widely and invited thereby cooperation from all laboratories of science. W. F. Petersen, Illinois, for many years has studied human beings day by day from biologic, constitutional, biochemic, and clinicopsychic viewpoints and demonstrated in kinetic graphs that the autonomic integration of biochemistry, of behavior, and of psychic reactions is never static, but in a constant organismal rhythmic swing varying in intensity in body types.

The normal association of the mental processes involves the maintenance of proper vascularization. Hippocrates recognized this and called specific attention to the disturbance caused by interference in the vascular supply caused by undue spasm or undue dilatation of the blood vessels ("Sacred Disease"—"Breaths",) and to changes in the mental function with undue hydration or dehydration of the tissues.

It is very difficult to prove that mental diseases of any particular type have increased. Furthermore, care must be used in drawing conclusions from the available data because the sample of the insane is drawn from a comparatively small population whereas the corresponding sample of the noninsane can be drawn from a much larger population. The apparent increase in the total number of commitments in our population may not be an actual increased incidence of insanity.

The rate of commitment correlated to the population is decidedly greater for urban than for rural districts—70.4 per cent to 27.1 per cent respectively. It indicates either that mental diseases become more socially discernible, or that large urbanization provides more adequate hospitals, and also more facilities through social agencies and mental hygiene clinics for the detection of the mentally sick. The growing social concern with the aged population and their senile and arteriosclerotic psychoses perhaps accounts for a considerable increase in admission to the psychiatric hospitals.

Statistics in the United States show that 60.9 per cent of the schizophrenics, 59.3 per cent of the epileptic psychoses, 76.4 per cent of the mentally deficient groups are unmarried. Therefore, the widespread belief that one of the characteristics common to mental defectives is abnormal fertility, appears mythical and is not supported by statistics. While an occasional feebleminded couple may show unrestrained propagation and increased fertility and, therefore, be responsible for a serious social problem, as a group, the fertility is low, and for various reasons, such as segregation, low income, and unattractiveness. The life expectancy of the insane population is less than the normal. For example, the death rate of the insane in the age group of 17 years is 13 to 20 times greater than that of the normal population; in the age group of 37 years, it is 10 times higher. The mortality of schizophrenics is 3½ times higher than that of their brothers and sisters; it is 5 times higher than the mortality of normals between the ages of 21 to 30. The psychiatric hospital population is increasing all over the world, due to earlier recognition, better hospital facilities, change of public attitude, greater trust in hospitals, and to the view that mental disease is an illness.

Inheritance of Mental Disease

The inheritance of derangement of the mental faculties of man indeed is a difficult problem, partly because it cannot be experimentally tested, partly because the diagnosis is often uncertain, and partly because the role played by environment is difficult if not impossible to define. The scientific achievements in genetics in reference to the localization of the genes in the chromosomes, their specific laws of appearance and combination in the mendelian progeny are not applicable. Personality and character are difficult to be studied genetically. The fruit fly's and the schizophrenic's germ plasm or their possible blastophoria are not in approximation, and their character or behavior scales are obviously not comparable.

If one analyzes pedigrees or family histories of mental patients, one finds many forms of taints in the ancestry and relatives which suggest neuropathic or psychopathic inheritance (polymorphism.) However, an equal number of noninsane of the same sex, age, race, social, moral, and economic status may present hereditary taints in a high proportion, so that often the pedigree of the normal is not much different from the abnormal. In the average population, schizophrenia occurs in 3 or 4 per thousand. In the schizophrenias, in some cases of feeblemindedness, and in the manic-depressive psychoses do hereditary factors appear to be of importance.

The question—is alcohol in the ancestry an etiologic factor in the production of endogenous psychoses—can be answered by the observations and studies reported in the literature, that on the whole the descendants of alcoholics are physically equal to and show no more incidence of mental deficiency or mental disease than the descendants of nonalcoholics.

A comparison of 581 children of nonpsychotic parents with 463 children of schizophrenic stock revealed: backward and nervous children were equal in the two groups, conduct disorders were 5 times higher among the psychotic offspring (lack of home control?), physical disease occurred more often in children of nonpsychotic parents, but the occurrence of nonorganic feeblemindedness was 10 cases in the normal against 4 in the schizophrenic parentage. One cannot speculate in anticipation since the various approaches including body typology, characterology, or psychoanalysis have failed to enhance our ability to prognosticate or to disclose the subclinical schizoid personalities.

In Sweden, Lundburg analyzed 2,232 rural families, in which at least one diseased person (propositus) existed, as to the occurrence and inheritance of schizophrenia. He concluded that the proportion paralleled the expectancy in a recessive type of mendelian inheritance, but that direct heredity was extremely rare. This verdict has been supported by Rüdin, Oberholzer, Meyerson, and others.

Rüdin and Weinberg concluded from approved statistical methods (Probanden Methode) on 701 families with 4,823 siblings, of whom 765 were schizophrenics, that certain forms of dementia praecox in families followed the recessive type of inheritance, but the mendelian laws cannot be established in the question of inheritance of mental disease, since the quantitativeness of its occurrence is too small for mendelian ratios. Heredobiologic percentages of the incidence of schizophrenia among relatives of schizophrenics amount to approximately 25 per cent, whereas the corrected incidence (Weinberg's method) is only 4½ per cent to 5½ per cent.

Vertical transmission implies from one generation to another, whereas horizontal transmission means appearance of mental diseases in members of the same generation. The former means if an ancestor—a parent—has a mental disease of a certain type, that type of mental disease is likely to appear in his "insane" descendants. Naturally, he is not bound to have insane descendants. The horizontal transmission brings up the question—if a brother or a sister has a specific type of mental disease, what type will likely occur in other siblings? It is a fact that the same mental disease rarely lasts more than three or four generations in any one group, but we find such relations: a grandparent's senium is ushered in with a paranoid psychoses, the second generation presents a similar psychosis at the involutional period, while in the third generation, the psychosis starts in early adult life. This is called anticipation of the psychosis, i.e. earlier appearance in succeeding generations. One can conclude that dementia praecox in a parent, in the majority of vertical transmissions, will present dementia praecox in the direct insane descendant; that in many descendants is a distinct trend towards lower mentality, however, not sufficient to warrant the term of "feeblemindedness."

The horizontal transmission of mental diseases tends on the whole to be more alike in the main features, which is to be expected since there is greater biologic, social, or environmental similarity. That one finds one or more siblings of a praecox to be "mentally defective" is explained by the observation that the very early symptoms of emotional immaturity, lack of social adaptation, and adjustment to home, school, and community life, and of mental standstill with regression, often suggest feeblemindedness when in reality it is a very early schizophrenia.

It is probable that hereditary factors are operating in the production of schizophrenia. How potent that hereditary factor is, and in what percentage it operates is not known. In certain families, dementia praecox occurs in higher incidence than in the general population, but definite hereditary taints and specific environmental influences cannot be isolated as causative factors.

Therapy

Electric convulsant therapy (E.C.T.) or electroplexy has replaced treatment by means of chemically induced convulsions, and may be safely and easily employed in out-patients as an intermittent follow-up therapy. It should not become the panacea for psychiatric disorders, and the "buzz treatment" will be discredited if the criteria for its use are not placed on scientific experiences. The brilliant results in the affective psychoses are not equalled in the schizophrenias, though convulsant therapy is useful in the socialization of dementing schizophrenias in state hospitals. Insulin therapy is superior to electric convulsant therapy in schizophrenia and increases the percentage of remission. Duration of the illness is important in the remission rate; i.e., if the patients are ill less than six months 60 per cent to 40 per cent can be paroled, if however the illness has been present for over three years not more than 20 per cent remissions can be expected. How the insulin-hypoglycemia effects the changes is unknown. The speculations cannot be proved if prefrontal lobotomy and electric shocks are alike, but vary only in intensity by silencing certain frontal lobe resonators and thus giving the frontothalamic brain structures time to adjust to simple but psychologically more acceptable and not disturbing patterns.

Prefrontal leukotomy (lobotomy) is a neurosurgical procedure of cerebral surgery which ameliorates certain psychoses or psychoneurotic reactions by cutting those fiber pathways in the central core of the white matter within each frontal lobe which convey dynamic interchanges between frontally derived psychologic impulses and the affect grading thalamus. Sectioning the fiber bundles from the frontal lobes results in degeneration of the dorsomedial nucleus of the thalamus which in turn produces alteration in emotional responses by disrupting ideational with affective experiences. The indications for lobotomy are: (1) intense and fearful apprehension with intractable obsessive preoccupation and agitation as seen in obsessive compulsive neurosis and in severe chronic anxiety states, (2) the chronically agitated and tormented involutional patient whose physical condition precludes electric shock therapy, and (3) the aggressive delusional and terrified hallucinating disturbed schizophrenic. However, all other forms of conservative treatment should be employed first; if these efforts fail, lobotomy is justified. The immediate effects of the operation are quite dramatic; some late effects are inertia, euphoria, increased suggestibility, procrastination, and convulsive seizures. The patient's ideas no longer dominate the emotional behavior. The social adjustment in terms of working capacity and ability to live outside an institution was obtained in half of the 331 patients of Freeman and Watts, in a nine years' survey, one-quarter remained home, and one-quarter are dead or institutionalized. Lobotomy fails in deteriorated cases but facilitates the patient's management. The operative mortality is under 3 per cent.

Alcoholism

The last chapter for our discussion must be the scientific approach to alcoholism, a serious public health problem of concern to old and young, to the nation, state, and community. Alcohol in its actions is a cortical depressant and impairs the finer perceptions and discriminations with disorganization of adaptive responses. The fact that alcohol ameliorates, at least temporarily, tensions in an introverted neurotic person by dissolving repressions, inhibitions, and conflicts, drives such a neurotic to an evanescent escape from his intrapersonal and social conflicts by using alcohol continuously and pathologically. As Strecker puts it: "The alcoholic addict is the person who cannot face reality without alcohol, and yet whose adequate adjustment to reality is impossible so long as he uses alcohol." Of the fifty million persons in the United States who use alcoholic beverages, some 6 per cent become excessive drinkers, and of the excessive drinkers about 25 per cent become chronic alcoholics—(there are more chronic alcoholics, 750,000, than active cases of tuberculosis in the country with almost total lack of hospital facilities for the former.) A comprehensive plan for research education for treatment and for legal control is fostered by the Research Council on Problems of Alcohol, in connection with medical schools and university hospitals. Since alcohol addiction is a psychnoeurosis with the object of shutting out reality inimical to emotional immaturity, the total socio-psychobiologic personality structure has to be readjusted and rebuilt with the aim to reach mature intelligence and the acceptance of a completely nonalcoholic future. An expedient to facilitate the goal is the conditioned reflex type of treatment of alcohol addicts which has shown excellent results in the hands of Doctors Kant and Kindwell at Wisconsin. Facilities for the scientific treatment of alcoholism, not sobering up or rest in

a jail or institution, are required. The veterans' facilities must be given the authority to institute conditioned reflex- with psycho-therapy for the alcohol veteran addict, and the same request holds true for our state hospitals.

Neuropsychiatry has much to offer for the peoples of the world who are suffering from the traumatic psychoneurotic experiences and nutritional frustrations of World Wars and living in the age of the atomic bomb crashings.

Antibiotics

By WESLEY W. SPINK, M. D.*
Minneapolis

W. W. SPINK

Doctor Spink graduated from Harvard Medical School, Boston, in 1932. Before taking his present position as professor of medicine at the University of Minnesota Medical School, the doctor was research fellow in medicine at Harvard Medical School and resident physician, Thorndike Memorial Laboratory, Boston City Hospital. He is a member of many organizations including: American Society for Clinical Investigation; American Society for Experimental Pathology; American Association of Immunologists.

AN ANTIBIOTIC has been defined by Waksman[1] as a chemical substance of microbial origin which inhibits the growth or the metabolic activities of bacteria and other micro-organisms. This fundamental concept of microbial antagonism has been known to bacteriologists for several decades, but in only recent years has this information been applied successfully to the treatment of bacterial diseases. From an historical point of view it is of interest that many years ago Emmerich and Löw prepared a bacterial extract called pyocyanase from *Pseudomonas aeruginosa (B. pyocyaneus)*.[2] This preparation, because of proteolytic properties, had a marked bactericidal effect on a number of pathogens. Pyocyanase was prepared at the Saxon Serum Institute in Dresden for the local treatment of skin infections and for the topical application to the nasopharynx of carriers of *Corynebacterium diphtheriae*. But therapy with pyocyanase did not come into general use because of its toxicity. Every surgeon with experience in the treatment of septic wounds has observed the appearance of a green exudate in wounds which meant the invasion of the tissues by *Pseudomonas aeruginosa* and the elimination of streptococci and staphylococci. More recent events leading up to a re-evaluation of microbial substances in the therapy of human infections will be discussed shortly.

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Deficiencies of the Sulfonamides in the Treatment of Infections

It is desirable to review the causes whereby the sulfonamides are being replaced by the antibiotics, particularly by penicillin, in the treatment of the more common bacterial infections. One may well ask if it is possible that following extensive use of penicillin it may become necessary to supplant this antibiotic with another chemotherapeutic agent for reasons similar to those leading up to the substitution of penicillin for the sulfonamides. Briefly, the reasons why penicillin instead of the sulfonamides is being utilized in many instances in medical practice today are as follows: (1) *Toxicity:* Extensive clinical application has demonstrated that all of the available sulfonamides are potentially dangerous drugs. In addition, these compounds have too frequently induced a state of serious hypersensitivity in patients taking the drugs; (2) *Development of sulfonamide resistant bacteria:* It is now common knowledge that species of micro-organisms highly sensitive to the antibacterial action of the sulfonamides may readily acquire the permanent characteristic of resisting high concentrations of the drugs. Brilliant examples of this biologic phenomenon are the dissemination of sulfonamide-resistant strains of gonococcus, and highly invasive strains of hemolytic streptococcus; (3) *Inhibition of sulfonamide activity by exudate and necrotic tissue:* Although the tissues may be invaded by a species of bacteria highly susceptible *in vitro* to the action of a sulfonamide, frequent therapeutic failures have ensued because the antibacterial activity of the drug has been nullified by a substance or substances in exudates and in the products of necrotic tissue; and (4) *Limited spectrum of antibacterial activity:* Common bacterial infections such as staphylococcal sepsis and those of the urinary tract due to gram-negative organisms have frequently failed to respond satisfactorily to sulfonamide therapy because the causative organisms have not been very susceptible to the action of the sulfonamides. Furthermore, there has been a need for an agent effective against *Mycobacterium tuberculosis*. In fact, this need has been partly responsible for the introduction of streptomycin.

It becomes evident that an antibacterial agent or agents which approach the ideal in the treatment

of human disease should possess little or no toxicity for the tissues; should not provoke a state of hypersensitivity in patients; should have a wide spectrum of antibacterial activity; should inhibit the growth of bacteria that are unaffected by the sulfonamides; should not induce the development and dissemination of resistant strains of bacteria; and should manifest a high degree of antibacterial activity in the presence of suppuration. With these factors in mind, the status of the available antibiotics may be ascertained.

Although a considerable number of antibiotics have been obtained from a variety of sources, only three need be included in the present discussion. When one reflects upon the difficulties that have been encountered with the large-scale production of penicillin and streptomycin, it is highly unlikely that many new antibiotics will find their way into medical practice in the near future. The three agents of practical clinical importance today are tyrothricin, penicillin. and streptomycin.

Tyrothricin

Tyrothricin was first obtained from *Bacillus brevis* by Dubos.[3] It was found to be a complex substance containing tyrocidine and gramicidin.[4] Crude preparations of tyrothricin are particularly active against gram-positive organisms such as staphylococci and hemolytic streptococci. While gramicidin is the active principal, purified material is not available for clinical use, nor essential, since the toxicity of gramicidin prevents it from being used systemically. Therefore, crude tyrothricin has been marketed for topical application. Tyrothricin has been most useful in dermatologic conditions, otolaryngologic infections, suppurating wounds, and in some phases of veterinary medicine. The dental profession has used tyrothricin locally for prophylactic and therapeutic purposes. When used topically in the proper concentrations, tyrothricin has little toxicity for the patient, and instances of the drug causing hypersensitivity must be extremely uncommon. The action of the antibiotic is not significantly suppressed by exudate or necrotic tissue, and the development of resistant strains of bacteria has not been a major clinical problem. Because tyrothricin has a relatively narrow spectrum of antibacterial activity, and because it can only be employed topically, this antibiotic has a limited demand in the field of medicine.

Penicillin

There is no doubt that the discovery of penicillin and the large-scale production of the antibiotic, constitute two of the most outstanding developments in the annals of the treatment of disease. One of the remarkable features about pencillin is that it possesses practically no toxicity for human cells. While the drug has provoked reactions such as fever and skin lesions, and instances of hypersensitivity have been recorded, these reactions have been relatively minor.[5, 6]

Fortunately, penicillin has a wide range of antibacterial activity, especially for the more invasive gram-positive species of bacteria. It is to be recalled that penicillin is not a single chemical agent, but that the commercial product now available is made up of several closely related chemical compounds with similar biologic activity.[7] It is now recognized that these penicillins are fractions F, G, X, K and dihydro F.[8] Recently some apprehension has been expressed because it appeared that commercial penicillin was losing its effectiveness in the treatment of syphilis.[8] There is little doubt that for a time there was an increase in the incidence of relapse of syphilis in patients treated with penicillin. Possible explanations for this failure was that a strain of *T. pallidum* had developed a resistance to penicillin, or that there was a change in the properties of commercial penicillin. Prompt investigations revealed that one of the fractions of commercial penicillin, namely, penicillin K, was only one-tenth as effective as fraction G against experimental syphilis in the rabbit. It was also observed that K is either rapidly eliminated or destroyed in the body. The present explanation for the partial failure of penicillin in the treatment of syphilis is that some commercial penicillin had more of the fraction K and less of fraction G. At present, relatively small amounts of K constitute the total product of commercial penicillin. The predominant fraction is G, and in general it would appear that the F and X fractions are as potent as G, though X is probably more active against the gonococcus and certain strains of streptococcus.

It should be appreciated in clinical practice that some species of bacteria have a natural resistance against the antibacterial activity of penicillin, such as gram-negative bacteria. In addition, some strains within species of organisms considered to be susceptible to penicillin may be relatively resistant. This includes some strains of staphylococcus and the less invasive species of streptococcus. If this deficiency of penicillin is recognized by clinicians, larger doses of penicillin may turn a therapeutic failure into one of success. The problem of strains with acquired resistance, which became so prominent in the downfall of the sulfonamides, has not been of major importance with penicillin. However, an occasional strain of staphylococcus has become highly resistant to penicillin in the human body.[9] The eradication of relatively resistant strains and the prevention of the development of resistance can probably be accomplished by employing adequate amounts of penicillin in the initial treatment of any infection. Some of us are a little apprehensive that the indiscriminate use of small oral doses of penicillin may foster the development of resistant strains of organisms. Another outstanding feature of penicillin is that its action is not materially affected by exudate and necrotic tissue.

In summary, penicillin is an extraordinary agent in the treatment of human infections because it possesses relatively little toxicity for human cells, it is unusually effective against several species of highly invasive pathogens acquired resistance of susceptible strains has not become a major clinical problem, and because the products of suppuration do not inhibit its activity.

Streptomycin

Streptomycin was the end result of a systemic search on the part of Waksman and his group[10] at Rutgers University for an agent effective against certain species of gram-negative organisms and *Mycobacterium tuberculosis.* Keefer and a group of investigators[11] have recently recorded the results of streptomycin in the treatment of several diseases.

In comparing the activity of streptomycin with penicillin some confusion might well arise since a unit value has been designated for both antibiotics. A unit of penicillin and a unit of streptomycin are entirely different quantitative entities. Waksman originally suggested the term "S" unit for streptomycin or that amount which would inhibit the growth of a standard strain of *E.* coli in 1 cc. of medium. In order to avoid confusion the Food and Drug Administration has recommended that the potency of all streptomycin should be determined upon the basis of the weight of pure streptomycin base. Thus 1 microgram of streptomycin base is the equivalent of 1 unit, and 1 Gm. of the base equals 1 million units.

While streptomycin is administered in solution by methods used for penicillin, one important distinction between the two drugs should be remembered. Penicillin can be effectively administered by the oral route for systemic infections. On the other hand, when streptomycin is given by mouth practically no streptomycin is absorbed from the intestinal tract although the drug is excreted in the feces virtually unchanged.

Thus far, the results of clinical investigations would indicate that streptomycin is more toxic than penicillin, but probably less so than the sulfonamides. The toxic reactions ascribed to streptomycin are local irritation at the site of injection; febrile reactions; skin lesions such as urticaria, erythema, maculopapular eruptions and purpura; headache and flushes; and histamine-like reactions with some lots. When 3 to 4 Gms. of streptomycin have been given daily for several months it has been observed that there was a selective neurotoxic effect on the eighth cranial nerve resulting in disturbances in equilibrium.

Since streptomycin has only recently been made available for general use a brief summary of clinical results is indicated. There is no doubt that streptomycin is an effective agent in the treatment of tularemia. This disease constitutes a clear-cut indication for the use of streptomycin. Certain types of urinary tract infections refractory to other drugs have responded to streptomycin therapy, especially those due to *Escherichia coli, Pseudomonas aeruginosa, Proteus vulgaris* and *Aerobacter aerogenes.* This also applies to cases of bacteriemia due to the foregoing species of organisms. Streptomycin is highly effective against meningitis caused by *Hemophilus influenzae.* There is some evidence that streptomycin is beneficial in some cases of peritonitis. High hopes were entertained for streptomycin in the treatment of brucellosis but, in general, clinical results have been disappointing. At the present time at the University of Minnesota Hospitals, sulfadiazine is being administered instead of streptomycin to patients with active brucellosis. Streptomycin is of doubtful value in the treatment of typhoid and Salmonella infections. Preliminary studies suggest that streptomycin may be useful in the treatment of pertussis.[12]

Considerable interest has centered about the potential value of streptomycin in the treatment of tuberculosis. While it is still too early to come to any definite conclusions with a disease noted for its chronicity and a tendency for remissions and relapses to occur, the cautious judgment of Hinshaw and Feldman[13] and their associates at the Mayo Clinic[14, 15] would indicate that streptomycin had a beneficial effect in the treatment of some of the more unusual pulmonary and extrapulmonary forms of tuberculosis. It is too early to ascertain the precise value of streptomycin in the treatment of tuberculosis, particularly in the pulmonary forms.

A disappointing feature about streptomycin of major clinical importance is that susceptible strains of bacteria may rapidly become highly resistant to the antibiotic.[16, 17, 18] Initial observations would indicate that this problem appears to be more serious with streptomycin than with the sulfonamides and penicillin. When it is considered that the plan of treatment in some forms of tuberculosis calls for a prolonged course of therapy, it is disconcerting to learn that the majority of strains of tubercle bacilli isolated from patients undergoing treatment acquired a considerable increase in resistance to streptomycin.[19] In a recent report, Finland and his group[20] have shown the rapidity with which organisms may become resistant to streptomycin in the human body in a group of patients with infections of the urinary tract. Within twenty-four to twenty-eight hours after initiating therapy, strains of gram-negative bacteria became extremely resistant to streptomycin. It has also been reported that strains of type b *Hemophilus influenzae* have become resistant in the human body as a result of treating children having meningitis due to this organism.[21]

Unlike the sulfonamides, the action of streptomycin does not appear to be inhibited by exudate and necrotic tissue. However, there is some evidence that a factor or factors in the human body appear to suppress the efficiency of streptomycin and prevent the eradication of streptomycin-sensitive organisms.[22]

In summary, streptomycin has a limited spectrum of antibacterial activity; it is more toxic than penicillin, but probably less so than the sulfonamides; the acquisition of resistance by bacteria appears to be a major clinical problem; and while the drug's action is not inhibited by exudate or necrotic tissue, some factor or factors in the human body diminish its antibacterial efficiency considerably.

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SCIENTIFIC EXHIBIT

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Erysipeloid

By W. L. MACAULAY, M. D.
Marshfield

W. L. MACAULAY

Doctor Macaulay is a member of the department of dermatology and allergy of the Marshfield Clinic, Marshfield. A 1942 graduate of the University of Minnesota Medical School, the doctor interned at San Bernardino County Charity Hospital in California before entering the U. S. Navy in 1943. Following sea duty he was assigned to serve with the Dermatology and Venereal Service at the United States Naval Hospital, Long Beach, California.

Introduction

ERYSIPELOID of Rosenbach is a disease in man which is caused by the *Erysipelothrix rhusiopathiae*, the organism of swine erysipelas. In Europe this disease has long been prevalent, but only within relatively recent years was it first introduced into this country.[1] It is an uncommon disease, and in the past only sporadic cases have been seen at the Marshfield Clinic. However, within a recent two month period, 5 independent cases of erysipeloid were observed. Several British authors,[2] recognizing an unusual incidence of the disease, have implicated meat which in normal times would have been condemned, but which at present is being passed for human consumption. Under present conditions, it is probable that our cases can be explained on the same basis. Undoubtedly, other physicians are encountering this condition with increased frequency. Therefore, it seems appropriate, at this time, to discuss the disease and record our experiences.

The Organism

The causative organism, the *Erysipelothrix rhusiopathiae*, is a gram-positive, non-motile rod which does not produce spores. It may be cultured in dextrose-brain broth or on blood agar from tissue excised from the eruption. In septicemia, the organism can be recovered from the blood stream. Apparently, it is capable of existing either as a harmless saprophyte or as a pathogenic parasite. Entry into the body via the gastro-intestinal tract is supposedly innocuous.

The Disease in Animals

Erysipeloid is essentially an animal disease. It has been found and described as occurring in a wide variety of animal species including swine, cattle, fish, crustaceans, mice, and wild animals. However, in the hog-raising industry the disease assumes widespread economic importance and may occur in epidemics. In pigs the disease manifests itself simply as skin lesions with mild constitutional symptoms ("diamond skin disease") or may produce septicemia, polyarthritis, endocarditis, and death.

The Disease in Man

In 1884 Rosenbach first described erysipeloid as a human skin disease. In man the disease is produced by contact with infected material. It occurs most commonly in butchers and fish-handlers and is regarded as an occupational disease.[3, 4] However, it is also seen in housewives, sportsmen, and others handling meat and fish.

The disease invariably appears on the hands in or around a wound produced by a scratch, abrasion, or incision. The first symptoms appear one to four days following injury and consist of pain and a peculiar eruption at the site of injury. The eruption consists of red-purple, tense, slightly elevated, sharply demarcated plaques which show a tendency to centrifugal spread with central clearing. Hemorrhagic vesicles may be present. The eruption is migratory in nature, and having once appeared, may break up into isolated plaques or sprout erratically on different parts of the hand and on other fingers. Multiple inoculations may occur simultaneously as in one of our cases. The purplish red color of the eruption is characteristic. Constitutional symptoms are usually mild. Lymphangitis and lymphadenitis occur in about 20 per cent of cases. A common concomitant of the eruption is arthritic pain and stiffness in one or more of the joints underlying the eruption. Suppuration does not occur.

The duration of the disease is variable, but in the majority of cases disappearance of the eruption and subsidence of joint pain occur in about three weeks. However, not uncommonly, the disease runs a more protracted course. Relapses and recurrences have been noted. Serious complications, including a generalized eruption,[3] septicemia, endocarditis, and death[5] have been reported.

Diagnosis

The diagnosis of erysipeloid rests principally upon the characteristic clinical picture and the history. Once one is familiar with the disease, recognition is not difficult. Errors in diagnosis arise chiefly in confusing the disease with a pyogenic cellulitis. When, in spite of hot fomentations, peripheral spread continues and "pointing" or suppuration fails to develop, one should think of erysipeloid. The organism may be cultured from excised tissue to

substantiate the diagnosis, but in typical cases this is not essential. A monocytosis may be noted on differential smear. Agglutination and intracutaneous tests are not reliable.

Treatment

As has been pointed out by Klauder,[3] the evaluation of any type of treatment in ersyipeloid is difficult because many cases run a self-limited or naturally abrupt course. Recommended therapeutic procedures are legion, but in the past none have met with constant favor. Immune serum is recommended for the more severe cases of erysipeloid, but its routine use is unwarranted.[3] Some observers have obtained good results with sulfonamides;[6, 7] but on the contrary, others have shown the sulfonamides to be ineffective in man and of meager value in experimentally infected mice.[8] Several authors[9, 10] have shown the efficacy of penicillin in treating mice experimentally infected with *Erysipelothrix rhusiopathiae*. Barber et al[2] recorded prompt recovery in 3 human cases treated with penicillin. Nicholas, in this country, reported a single case treated successfully with penicillin.[11]

Report of Cases

Case 1.—F. H., a white man, age 39, employed as a butcher, cut his right index finger while scraping a pork head to obtain meat for sausage. About four days later an area of redness developed around the wound. He consulted his physician and was started on hot compresses and oral sulfadiazine. In spite of this, the lesion continued to spread peripherally, and the right second metacarpal-phalangeal joint began to ache.

On examination the right index finger was of purple-red color. The small healing wound was noted. At the palmar base of the third right finger an ill-defined patch of similar color was developing. There was some discomfort in the involved finger joints, but no limitation of motion. No lymphangitis nor lymphadenopathy was observed. Temperature was 97.4 F.; urinalysis, negative; hemoglobin, 18.3 Gms.; RBC 5,970,000; and WBC 10,700. The serology was negative. A diagnosis of erysipeloid was made.

The patient refused hospitalization for penicillin therapy, and it was decided to continue with hot compresses and sulfadiazine. Four days later he was again seen at which time there was central clearing around the original wound, but the lesion was spreading over the palmar and dorsal surfaces of the hand. Hospitalization was again advised but refused. The patient was not seen again.

Case 2.—H. W., a white man, age 32, a butcher, scratched the distal part of the left fourth finger on a sharp beef bone. About three days later redness and some swelling were noted near the original scratch. He initiated hot soaks, but the lesions continued to encompass and spread up the finger. Six days after the onset of the disease he visited his physician who continued hot compresses and prescribed sulfanilamide by mouth. Two days later the eruption appeared at the bases of the third and fifth finger. At this time equal doses of sulfathiazole and sulfadiazine were prescribed. The following day the patient was referred here.

Examination of the right hand revealed only superficial scaling at the site of the original scratch on the palmar surface of the distal index finger. The proximal parts of the third, fourth, and fifth fingers and the adjoining portions of the palm showed sharply outlined, slightly elevated, tense, purple-red plaques. The patient complained of pain in the fifth metacarpal-phalangeal joint and itching at the site of the lesions. The right epitrochlear node was enlarged. Temperature was 98.6 F.; urinalysis, negative; hemoglobin 15.9 Gms.; RBC 5,680,000; WBC 10,850; and differential: Segs 62 per cent, Eosin. 3 per cent, Lymph. 28 per cent, Mono. 7 per cent. The serology was negative. A diagnosis of erysipeloid was made. The patient was hospitalized. He received 30,000 units of penicillin intramuscularly five times daily. By the second hospital day, beginning recession was apparent, i.e., the rubor was less intense, and the arthralgia and itching had disappeared. By the fourth hospital day the eruption was barely visible, and he was discharged on the succeeding day. A total of 750,000 units of penicillin had been administered. He was observed three days and again seven days after discharge. There was no recurrence.

Case 3.—R. A., a white man, age 22, also a butcher, scratched his left hand while at work in his shop. About four days later he observed redness at the site of injury. With each succeeding day further peripheral spread was evident. He was first seen on the seventh day after injury.

Examination revealed a sharply outlined, dusky red erythema with slightly elevated borders involving the dorsal web between the first and second fingers of the left hand and extending well onto the back of the hand. Movement of the thumb produced some discomfort, but otherwise there were no subjective complaints. Temperature was 98.8 F.; urinalysis, negative; hemoglobin, 15.4 Gm.; RBC 5,690,000; and WBC 10,350. The clinical diagnosis was erysipeloid.

The patient was hospitalized and given 30,000 units of penicillin intramuscularly every three hours. On the second hospital day there was definite fading of the lesion, and the thumb was freely movable without pain. He was discharged on the fifth hospital day with complete subsidence of the eruption. A total of 1,080,000 units of penicillin had been given. Follow-up examination one week after discharge revealed no recurrence.

Case 4.—E. O., a white man, age 43, scraped and cleaned several fish while on a fishing trip. About six days later, without any evidence of a scratch or wound, he observed a small circular area of erythema on the ulnar aspect of the right hand. Within

a few days the initial lesion spread to involve the proximal part of the right fifth finger. He was referred here for diagnosis.

On examination several well demarcated areas of reddish purple color, slightly elevated, and tense were noted on the antithenar eminence of the right hand and on the proximal and distal portions of the right fourth finger. A ring-like lesion of this type completely encircled the proximal two-thirds of the fifth finger (figure 1). The proximal interphalan-

Fig. 1—Note lesions of erysipeloid on distal and proximal portions of fourth finger. The proximal two-thirds of the fifth finger is completely encompassed by the eruption.

geal joint of the fifth finger and the fourth metacarpal-phalangeal joint were tender to touch. Serology and urinalysis were negative. A diagnosis of erysipeloid was made and the patient was referred back to his physician for penicillin therapy. He received 25,000 units every three hours. Within twenty-four hours definite improvement was apparent. A total of 600,000 units was administered. There was no recurrence.

Case 5.—H. P., a white woman, age 69, was employed as a scullion in a restaurant. Among other things, her job entailed scouring the meat block for which she used steel wool. Four days before admission she noticed redness and slight swelling on the distal portion of the third left finger. In rapid succession similar areas appeared on the second left finger, the right thumb, and the web between the thumb and index finger of the right hand. "Blood blisters" superimposed several of the lesions. The patient opened and drained these herself.

On examination the involved areas showed tense, slightly swollen, dark red plaques which were painful to touch. Both hands showed numerous small scratch marks, presumably from steel wool. There was no evidence of lymphangitis nor lymphadenopathy. Temperature was 98.6 F.; serology and urinalysis, negative. The patient complained of moderate itching and throbbing, but otherwise she had no subjective complaints. A diagnosis of erysipeloid with secondary pyogenic invasion at the ruptured vesicle sites was made.

Treatment was begun with 30,000 units of penicillin intramuscularly every three hours, and hot compresses were applied to the hands. The lesions became more tense and painful, and on the third hospital day obvious abscess formation was present in the right hand. Surgical incision and drainage were performed, the material obtained being largely serous in nature and to a lesser extent purulent. Penicillin was continued, and thereafter recovery was uneventful. The patient was discharged on the thirteenth hospital day. A total of 1,330,000 units of penicillin was administered. This case was considered as one of erysipeloid complicated with pyogenic infection introduced when the patient punctured and drained the original hemorrhagic vesicles.

Discussion

The first 4 cases presented are typical of the clinical picture of erysipeloid. The fifth case is not representative. Three of the 5 cases occurred in butchers and serve to re-emphasize the occupational nature of the disease. The first 2 cases demonstrate the apparent inability of sulfonamides to control erysipeloid. The second case later responded promptly to penicillin. The third and fourth cases showed rapid subsidence of symptoms with penicillin as the sole therapeutic agent. In retrospect, smaller total dosages of penicillin would probably have sufficed. The anticipated treatment of future cases embodies the use of penicillin in oil or oral penicillin to eliminate the necessity of hospitalization.

Summary

An increased incidence of erysipeloid of Rosenbach has recently been observed in this locality. Further confrontment with the disease is anticipated.

The clinical picture of the disease, its etiology, and treatment are discussed.

Five cases of the disease are presented.

Penicillin is the treatment of choice.

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Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Bronchiectasis

Bronchiectasis, or bronchiectasia, was first described by Laënnec in 1819. The term bronchiectasis merely means dilated bronchus. The disease is usually lobar in distribution and associated with an infection which gives rise to a destructive process in the walls of the involved bronchi and adjoining lung parenchyma. The diseased lobe is cyanotic, atelectatic and fibrotic. The bronchial mucous membrane is replaced by indolent granulations and scar tissue bathed in a copious mucopurulent discharge with a characteristically pungent foul odor.

The disease is characterized by fever, foul breath, hemoptysis, and the expectoration of varying amounts of putrid sputum. Acute exacerbations frequently occur which force the patient to seek his bed for short periods throughout the year. It is progressive and not infrequently spreads to other parts of the bronchial tree.

The treatment of bronchiectasis has varied greatly in the past and has been essentially symptomatic. The various treatments now used may be divided into two types: (1) nonoperative, and (2) operative.

Nonoperative: Rest, postural drainage, diet, climate, intravenous therapy, bronchial lavage, vaccines. Very few patients fail to enjoy remissions even though they receive no treatment. There is, however, little evidence to indicate that spontaneous cures occur frequently. Of all the forms of nonoperative therapy the most valuable is postural drainage which enables the patient to evacuate the involved areas, ridding them of the copious secretions which otherwise would have to be removed by continual coughing. Different types of drug therapy assist in reducing the fetor of the sputum for short periods.

Operative: Bronchoscopy, bronchography, pneumothorax, plombage, phrenicotomy, thoracoplasty, cautery pneumonectomy, pneumotomy, oleothorax, ligation of the pulmonary artery and lobectomy. All of these have been employed with good, bad, and indifferent results. This is not strange when we note that all operative procedures, other than lobectomy, try through mechanical means to promote more adequate drainage of the involved lung, or through actual compression to rest the diseased area and promote healing. Lobectomy, the treatment of universal choice, presents the most logical method so far suggested. It combines all the good effects obtained through the other means, and in addition, eliminates the diseased process. Once the focus is eliminated there is less chance of involvement in other areas. All chance of the numerous complications are removed by one simple procedure. A decade ago this would have appeared radical because of the high incidence of complications arising following the procedure. Now, however, with increased experience in operative technic the mortality of lobectomy is less than that following gastric resection. It is now possible to resect only small segments from a lobe of the lung, thereby preserving a maximum of healthy pulmonary tissue.

Preoperative postural drainage must be carried out properly, and when combined with aerosol inhalations of penicillin, is most valuable. It reduces the amount of coughing, promotes drainage, lessens toxemia, and attenuates the bacteria. Penicillin given over long periods of time is of little value because of the well known increased tolerance, on the part of the bacteria, to the drug.

No treatment will prove satisfactory unless care is taken to eliminate all contributory conditions, particularly those involving the paranasal sinuses. Bronchoscopy and bronchography, when carefully combined, assist the surgeon materially in locating the diseased tissue and in eliminating any other predisposing factors such as foreign body, stricture, or neoplasm.—JOSEPH W. GALE, M. D., *University of Wisconsin.*

Notes on Clinical Pathology

Editors—WALTER H. JAESCHKE, M. D., University of Wisconsin, Madison, and
S. B. PESSIN, M. D., Marquette University, Milwaukee

Tests of Biliary Function

The production of bile including the formation and excretion of bilirubin as a part of pigment metabolism is one of the best known functions of the liver. At the State of Wisconsin General Hospital we use four procedures based upon this function. These are as follows:

A. Bilirubin Detection
B. Icterus Index Determination
C. Van den Bergh Reaction
D. Urobilinogen Estimation

Some knowledge of pigment metabolism is necessary for the intelligent use of these procedures. It is admitted that the discussion given here is far from complete and that some workers are not in agreement with all details. We, nevertheless, consider it useful.

Pigment Metabolism. Bilirubin, the chief pigment of bile, is derived from the hemoglobin of disintegrating erythrocytes by a "break-down" process in the cells of the reticulo-endothelial system which include the Kupffer cells of the liver. Immediately after formation, according to Coolidge, the bilirubin combines chemically with valence bonds to the albumin of the plasma to form a complex which gives an indirect van den Bergh reaction only. It was once believed that the indirect reacting bilirubin was attached to serum globulin, but this has since been shown to be incorrect. For convenience, the term *hemobilirubin,* is commonly used for this pigment which is normally present in small amounts in the blood stream. The parenchymatous cells of the liver do not seem to have a part in the process of its manufacture but are only involved in the excretion of bile pigment into the bile canaliculi. During the process of excretion the bilirubin-plasma albumin chemical bond is broken, but the bilirubin remains loosely attached to the albumin as a dissociable complex. Excreted bilirubin gives a direct van den Bergh test in addition to an indirect test. The term *cholebilirubin* is often used for this pigment.

To continue the discussion, it can be said that *cholebilirubin* entering the intestinal tract by way of the common bile duct is converted into *urobilinogen* by the action of anaerobic bacteria. Much of the urobilinogen is excreted in the feces as urobilinogen or its oxidation product, *urobilin,* but a portion is reabsorbed and carried to the liver by the portal circulation. In the liver it is considered likely that a portion is utilized in hemoglobin synthesis, a small amount reconverted into bilirubin and a part re-excreted in the bile; also it seems that a small amount escapes in the circulation and is excreted by the kidneys. The traces of urobilinogen normally present in the urine are rapidly oxidized into urobilin when voided specimens are allowed to stand.

A. *Bilirubin (Cholebilirubin) Detection in Urine Specimens.* (See text books for technic.)

Interpretation of results:

1. *In partial or complete biliary obstruction* it is thought that a rupture of blocked distended canaliculi or an increased permeability of these structures allows bile to gain access first to the lymph spaces of Desse and from there to the thoracic duct and blood stream. Cholebilirubin in the blood stream is excreted by the kidneys and gives a greenish yellow, yellow, or brown color to the urine, which upon shaking is imparted to the foam.
2. *In hemolytic jaundice without significant damage* there is no obstruction to bile passages, hence, no cholebilirubin in urine specimens.

B. *Icterus Index Determination on Serum or Plasma Specimens.* (See text books for well known procedures and interpretations.)

Attention, however, is called to the use of indices at frequent intervals and plotting results as a curve to obtain certain diagnostic data. (According to the University of Minnesota Hospitals Intern Manual.)

1. "Complete biliary obstruction shows a rapidly rising curve with a high plateau."
2. "Obstruction due to stone shows a rapid rise and a gradual fall. If partial obstruction persists and especially if it is complicated by biliary cirrhosis, a low plateau results."
3. "Severe acute parenchymatous jaundice shows a rapid fall if recovery occurs." (Example—catarrhal jaundice.)
4. "Chronic parenchymatous disease shows low fluctuating curves. Each small rise signifies an acute episode of active liver damage or a period of increased blood destruction with persisting liver dysfunction."
5. "In 90 per cent of cases of calculus jaundice the icterus index remains below 100; the converse is true if jaundice is due to cancerous biliary obstruction."

C. *Van den Bergh Reaction on Serum or Plasma Specimens.*

Much argument centers about the use of the qualitative reaction, with many clinicians and clinical pathologists claiming that it has failed in too many instances to clearly differentiate between the various types of jaundice. The indirect or quantitative reaction is still commonly used, but even here the procedure has not retained universal favor, because visual colorimetric readings repeatedly have been shown to lack real accuracy. Attention is called, however, to the accurate photo-electric method introduced by Mallory and Evelyn and now described in some of the latest texts on laboratory methods.

(Continued on page 1092)

As It Looks to Your State Board of Health

(These timely discussions of health problems are prepared by staff members as a special service to Wisconsin's physicians.)

Fluorine in Relation to Dental Health

In 1937, the U. S. Public Health Service requested that a survey be made of all water supplies in the United States as to their fluorine content. This brought out the fact that many areas in the United States have fluorine in varying amounts in their water supplies. Surveys showed that the residents of those areas that had less than 2.0 p.p.m. fluorine, had no objectionable mottling of the enamel, while those in areas having higher amounts showed increased mottling as the fluoride content increased. The survey in Wisconsin showed that an area extending above and below Green Bay had varying amounts of fluorine naturally present in its public water supplies. The highest concentration of fluorine was in Green Bay, which had 2.3 p.p.m. Surveys there showed slight mottling of the teeth.

Following reports from the U. S. Public Health Service that they have found less dental decay in areas having fluorine present in their public water supplies, surveys were carried on in many parts of the United States to determine whether there was a significant reduction in dental decay in the fluorine areas. In Wisconsin, the State Board of Health sponsored a survey of dental caries in Green Bay (2.3 p.p.m.,) and used Sheboygan (.05 p.p.m.) as a control. About 1,700 children (12 to 14 years) were examined in each city. Only those children who were born in and had maintained a continuous residence and water history in their respective cities were included in this survey.

The results of the survey showed that the Green Bay children had only one-third the amount of dental decay in the permanent teeth that the children in Sheboygan had.

These figures were exactly in line with some 30 surveys carried out in different parts of the United States by the U. S. Public Health Service.

Recently the State Board of Health conducted a survey in these same two cities, Green Bay and Sheboygan, to see what effect fluorine had on reducing dental caries in deciduous teeth. The results of this survey on about 500 kindergarten children (5 to 6 years) in each city, showed that the Green Bay kindergarten children had only one-fourth the dental decay of the Sheboygan children.

In the surveys that were conducted by the U. S. Public Health Service throughout the United States where cities had varying amounts of fluorine in their public water supplies, it was found that areas having only 1 p.p.m. of fluorine had about the same immunity from dental decay as areas having higher amounts. This was an important finding because with only 1 p.p.m. in the water there is no chance for mottling of the teeth. It likewise paved the way for the artificial addition of 1 p.p.m. of fluorine to public water supplies to reduce the incidence of dental caries which several cities in the United States including Sheboygan, Wisconsin, are now carrying on.

While the mechanics of the artificial addition of fluorine to water supplies are still experimental, and proper safeguards must be worked out to insure that the exact amount of fluorine is constant in the water, there is nothing experimental about the action the fluorine has in reducing the amount of dental caries when it is once placed in the water. No public health measure ever had a greater mass of favorable data prior to its introduction than this one.

The Wisconsin State Board of Health has given favorable consideration to the applications of cities that wish to start fluorination projects on an experimental basis where proper controls are set up. The fluorine committee of the Wisconsin State Dental Society is actively cooperating with the State Board of Health in this important work—F. A. BULL, D. D. S., M. S. P. H., *Supervisor, Dental Education.*

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« « « EDITORIAL » » »

Enough Flowers For All

AT THE conclusion of a successful annual meeting it is always pleasant to pass out bouquets and relax in the contentment of a task reasonably well done. The office of the Secretary has received many fine compliments on the conduct of the meeting, but while we enjoy posies as much as Ferdinand, in all fairness we feel prompted to pass the bouquets along where they really belong.

The formation of a scientific program is a rather complicated process, and without the finest type of cooperation on the part of many physicians, the office of the Secretary would be helpless in developing any type of program.

As soon as one hazards enumerating specific individuals who are deserving of special commendation he runs the risk of inadvertently omitting someone who is worthy of special praise. But in spite of such dangers of unintentional slight we wish to make a few special bows to those who contributed greatly to the success of our 1946 meeting.

Heading the list is a group of seventeen out-of-state speakers who came from points as far away as Boston, New Haven, and New York, to give freely of their time and energy so that members of the State Medical Society of Wisconsin could share with them experiences and knowledge of medical science which will improve the medical care given the citizens of Wisconsin who are patients of our members. To all of them we extend a heart-felt thank you for their generous help.

Among the members of the Council on Scientific Work there were Drs. E. R. Schmidt, and C. D. Neidhold who gave us special help. Doctor Schmidt and his secretary, Miss Helen Crane, built up a scientific program of outstanding value, while Doctor Neidhold prepared a scientific exhibit which added much to the teaching part of our program.

Physicians who assisted Doctor Schmidt with the development of exceptionally strong section programs were: Drs. R. M. Kurten, Racine; B. E. Urdan, and F. H. Haessler, Milwaukee; and Chester Kurtz, J. E. Gonce, Jr., L. V. Littig, E. A. Pohle, and A. R. Curreri, Madison.

As special features of the scientific programs, Dr. H. Kent Tenney, Madison, assisted with the choice of medical motion pictures, and Dr. H. J. Olson, Milwaukee, assisted with the obstetrical manikin demonstrations.

And while we're skimming the field to point out a few individuals who helped make the 1946 Annual Meeting program a success we would be remiss if we overlooked the assistance given us by Mr. Alvin Monroe of the Milwaukee Association of Commerce; Mr. Al Bowitz of the Milwaukee Auditorium; Mr. Louis Limecooley, manager of the Hotel Schroeder, and his associate, Miss Adeline Stollenwerk, who completed all arrangements for our meeting rooms and meal service.

To all of those mentioned, and the dozens of others who assisted by way of conducting round-table discussions and clinical demonstrations, we owe a debt of gratitude. While we in the Secretary's office contributed our bit by way of carrying out instructions given to us, our efforts would have been of no avail had not so many members of the profession given generously of their time and effort in developing a program of outstanding value to the members of the Society.—RTR

CHARLES A. DAWSON, M. D.
President, State Medical Society of Wisconsin

Dr. Charles A. Dawson, River Falls, who was born in Kankakee County, Illinois, in 1881, graduated from the University of Minnesota School of Medicine with the class of 1903. After practicing in Glyndon, Minnesota, and Minneapolis, the doctor moved to River Falls, Wisconsin, in 1911 and has resided and practiced in that city ever since, with the exception of one year that he spent in Army service during World War I.

Doctor Dawson serves as secretary of the State Board of Medical Examiners with offices in River Falls, and holds the honorary position of chairman of the State Board of Veterans Affairs in Madison.

The doctor's family includes his wife, the former Jessie May Haston, and five children: Lawrence H., superintendent of schools, River Falls; Lowell "Red" head coach of the Buffalo Bison, professional football team in Buffalo, New York; Charles A. Jr., in business in Cass Lake, Minnesota; Mrs. Ida Jane Dorgan, Doctor Dawson's secretary; and Bill, a premedical student at River Falls State Teachers College.

Annual Meeting Sets New Attendance Record as Veteran Members Return

Dr. W. D. Stovall, Madison, Named President-Elect

THE 1946 Annual meeting, held in Milwaukee October 7–8–9, was in a real sense a "victory meeting" with a large number of veteran members in attendance for the first time since the close of World War II. The total registration was well over the 2,100 mark, exceeding the number of physicians and guests who attended the 1944 meeting, which had been the largest meeting in the history of the Society.

This year's meeting will go down in history as one of the most important conferences in the one hundred and five years of the Society's activity. While the scientific program commanded the major attention of those in attendance, the business sessions of the House of Delegates presented problems of unusual importance. The major issue confronting the delegates was the acceptance or rejection of the majority and minority reports of the special committee created by the House of Delegates last June to consider the development of the experimental program of voluntary sickness insurance in Milwaukee County into a plan of state-wide scope under the specific direction of the State Medical Society of Wisconsin. The Reference Committee on Resolutions, before which all those concerned with the insurance program appeared, was in continuous session from 9:00 a.m. until 6:00 p.m. Monday, and completed its report shortly after midnight. The entire forenoon of the following day was devoted to action on the reports of the various reference committees, with major attention given to the report of the Reference Committee on Resolutions. After serious and earnest deliberation on the part of all delegates, the majority report of the special committee on the insurance program was adopted, and steps have been taken by the Council to implement the program and develop the Milwaukee county experimental program on a state-wide basis.

Dr. W. D. Stovall, President-Elect

Among other important actions on the House of Delegates was the election of officers, following the recommendations of the Committee on Nominations. Those named to various offices are:

W. D. Stovall, Madison—President-elect.
Gunnar Gundersen, La Crosse—Speaker of the House of Delegates.
A. A. Cantwell, Shawano—Vice-speaker of the House of Delegates.
S. E. Gavin, Fond du Lac—Delegate to the American Medical Association to succeed himself.
J. C. Sargent, Milwaukee—Delegate to the American Medical Association to succeed himself.
L. O. Simenstad, Osceola—Alternate Delegate to the American Medical Association to succeed himself.
E. J. Carey, Milwaukee—Alternate Delegate to the American Medical Association to succeed himself.

Councilors elected or re-elected to replace those whose terms expired this year are:

C. O. Vingom, Madison—Third District
E. H. Spiegelberg, Boscobel—Fourth District
A. H. Heidner, West Bend—Fifth District
S. E. Gavin, Fond du Lac—Sixth District
J. W. Truitt, Milwaukee—Twelfth District

Committee Appointments

The following committee appointments were announced by President C. A. Dawson:

Committee on Cancer
*A. R. Curreri, Madison
*L. W. Peterson, Shawano
Robert Baldwin, Marshfield
W. S. Bump, Rhinelander, chairman

Advisory Committee on Care of Crippled Children
*W. P. Blount, Milwaukee
C. M. Ihle, Eau Claire
H. A. Sincock, Superior, chairman

Committee on Coordination of Medical Services
E. F. Tierney, Portage
C. O. Vingom, Madison, chairman

Committee on Goiter
*E. W. Schacht, Racine
E. S. Gordon, Madison, as an ex officio member
A. S. Jackson, Madison, chairman

Committee on Grievances
J. W. Prentice, Ashland, chairman

Committee on Health and Public Instruction
*Norbert Enzer, Milwaukee, chairman

Committee on Hearing Defects
*W. E. Grove, Milwaukee, chairman

Committee on Hospital Relations
*M. L. Jones, Wausau
J. W. Smith, Milwaukee
J. E. Habbe, Milwaukee, chairman

Committee on Industrial Health
E. W. Miller, Milwaukee
D. E. Dorchester, Sturgeon Bay, chairman

Committee on Maternal and Child Welfare

E. C. Cary, Reedsville
W. C. Stewart, Kenosha, chairman

Committee on Medical Economics and Voluntary Sickness Insurance

*Robert Krohn, Black River Falls (reappointed and designated as chairman)
H. J. Lee, Milwaukee

Committee on Medical Education and Hospitals

F. J. Pohle, Madison
F. D. Murphy, Milwaukee, chairman

Council on Medical Services and Public Relations

R. G. Arveson, Frederic, chairman
J. S. Supernaw, Madison
R. P. Montgomery, Milwaukee
C. R. Marquardt, Milwaukee
A. E. Rector, Appleton

Committee on Mental Hygiene and Institutional Care

O. H. Epley, New Richmond
H. H. Christofferson, Colby, chairman

Committee on Public Policy

Hart Stang, Eau Claire
S. E. Gavin, Fond du Lac, chairman

Committee on Rural Health and Accident Prevention

*R. L. MacCornack, Whitehall, chairman

Council on Scientific Work

F. W. Madison, Milwaukee

Committee on Tuberculosis and Chest Diseases

*L. O. Simenstad, Osceola, chairman

Committee on Visual Defects

*R. P. Sproule, Milwaukee
J. K. Trumbo, Wausau, chairman

Special Advisory Committee to the State Department of Public Welfare

*H. Kent Tenney, Madison
*H. L. Greene, Madison
*E. W. Mason, Milwaukee
*J. L. Garvey, Milwaukee
*W. A. Munn, Janesville, chairman

PAST-PRESIDENTS' LUNCHEON

Seated: (left to right) Drs. Gunnar Gundersen, La Crosse, 1942; J. F. Smith, Wausau, 1926; S. E. Gavin, Fond du Lac, 1937; H. H. Shoulders, president of the American Medical Association; F. G. Connell, Oshkosh, 1923; S. J. Seeger, Dallas, Texas, 1934; J. C. Sargent, Milwaukee, 1938; Standing: (left to right) Drs. R. P. Sproule, Milwaukee, 1941; C. A. Dawson, River Falls, 1947; Charles Fidler, Milwaukee, 1945; P. R. Minahan, Green Bay, 1946; R. G. Arveson, Frederic, 1940; W. D. Stovall, Madison, 1948; A. J. Patek, Milwaukee, 1913; J. M. Dodd, Ashland, 1912.

Committee on Incurably Ill

*D. J. Twohig, Fond du Lac
*D. F. Gosin, Green Bay
*P. R. Minahan, Green Bay
*W. D. Stovall, Madison, chairman

Committee Advisory to the Motor Vehicle Department

*E. H. Jorris, Madison
*John Malec, Madison

Centennial Exposition Committee

All past-presidents were named to this special committee, and they were charged to appoint a special executive committee to implement the program.

* Reappointment.

Veterans Play Active Role

One noteworthy feature of the 1946 Annual Meeting was the active role played by the returning veteran members. Their presence was felt everywhere as they participated in discussions before the House of Delegates and in the various scientific programs. As a means of expressing their welcome to all returning veterans, the Councilors, Officers, and Delegates acted as official hosts at a dinner on Monday night, at which Dr. George Lull, secretary and general manager of the A.M.A., was guest speaker. The following noon more than 100 veteran members attended a special luncheon arranged under the direction of Maurice Hardgrove, for the purpose of discussing special problems of returning medical officers, and affecting a continuing organization.

Shoulders, Annual Dinner Speaker

The annual dinner, attended by more than 400 physicians and their wives, featured an inspiring address by H. Harrison Shoulders, president of the American Medical Association, who spoke on "The Promotion and Extension of High Quality Medical Care and the Preservation of Freedom in Medicine."

The meeting concluded with the presentation of a gavel to immediate Past-president P. R. Minahan, who spoke briefly of his pleasure in serving the physicians of Wisconsin as their president during 1946.

Special Features

As a means of developing a diversified scientific program, the Council on Scientific Work introduced several new features this year, and without exception they met with unqualified success. In addition to the customary round-table luncheon discussions the Council provided three clinical demonstrations and five manikin obstetrical demonstrations. The enrollment for these various demonstrations indicates the value of incorporating these features in future programs.

During the general scientific sessions a full day's schedule of medical motion pictures was shown in an adjoining hall. The pictures were carefully selected by H. Kent Tenney, Madison, and from responses of those who viewed the films it was evident that they contributed greatly to the scientific value of the programs presented.

Exhibits Largest in History

While the demand for commercial exhibit space was unusually great, the Council on Scientific Work presented a large scientific exhibit which was well received by those in attendance. Many exhibits were contributed by physicians from the neighboring states of Iowa, Illinois, and Minnesota, in addition to displays presented by Wisconsin medical groups. Out of a total of 115 exhibits, 28 were of a strictly scientific character.

Past-Presidents Meet

The Past-presidents' Luncheon, at which Doctor Minahan served as host, and Doctor Dawson, incoming president, and Doctor Stovall, president-elect, were guests of honor, provided an occasion for the formation of plans for a special celebration in connection with the Centennial Celebration in 1948. A special committee has been appointed, and plans will be announced at a later date.

Two out-of-state guests were present, H. Harrison Shoulders, Nashville, Tennessee, president of the A.M.A., and Stanley Seeger, Dallas, Texas, president of the State Society in 1934.

The success of the 1946 meeting was made possible only by the concerted efforts of many physicians. The Council on Scientific Work received notable assistance from section chairmen and many physicians who assisted with the development of scientific exhibits. The Secretary's office owes a debt of gratitude to all who enabled the office staff to complete arrangements so that the meeting was conducted with dispatch and a minimum of confusion.

AMERICAN ACADEMY OF PEDIATRICS

Wisconsin Study of Child Health Services

As the study enters the home stretch the directors, Mr. Thomas Doran and Dr. H. Kent Tenney, Jr., wish to express their gratitude to the physicians and hospitals of Wisconsin for the splended cooperation they have received. Many physicians have been asked recently to assist in securing some special information from hospitals which is vital to the completion of this phase of the study. Before the study can be completed it is necessary to know which physicians are in private practice. Follow-up cards are to be sent to all physicians who did not return the schedules sent out in July. As this is the last time physicians will be asked to fill out a questionnaire on this subject, your State Society urges you to cooperate in order that the study can be speedily and completely finished.

Physicians in Service

For many months material in this section was carried under the title of "The Nation at War." With physicians still entering service, with many returning to reestablish themselves in civilian practice, and with many planning to continue in service for an indefinite time, it is the decision of the *Journal* to continue the section under a more timely title.

Returning Veterans

Lieutenant Norman O. Becker of Fond du Lac, who was discharged from the Navy August 22, is now surgical resident at Cleveland City Hospital, Cleveland, Ohio. After receiving his commission in March 1943, Lieutenant Becker was granted a deferment to complete internship and a 9 month assistant residency in surgery at Cleveland City Hospital. Beginning active duty October 10, 1944, he was assigned a month's duty at the U. S. Naval Hospital, Oakland, California. The doctor then reported for duty as assistant ship's medical officer on board the USS Sarasota (APA 204) on the Pacific, participating in the invasions of Lingayen Gulf and San Narciso on Luzon, and Okinawa and Io Shima in the Ryukyus. He returned to this country in August 1945 and served in the thoracic surgery department of U. S. Naval Hospital, Corona, California, until released from active duty.

He wears the American Theater, Asiatic-Pacific Theater (with 3 battle stars,) and Philippine Liberation ribbons.

Captain L. J. Earney, La Crosse, who entered the Army August 1, 1942 from internship, received a discharge May 23. He is now serving as resident in surgery at Milwaukee County General Hospital.

During his term in the armed forces, the doctor rendered service with the following units: Medical Field Service School, Carlisle Barracks, Pennsylvania; 253 C. A., 36 C. A., and Station Hospital, St. Thomas, Virgin Islands; and Station Hospital, Camp McCoy, Wisconsin. Captain Earney wears the American Theater ribbon.

Captain Ralph W. Garens has resumed his civilian medical practice in Milwaukee since receiving a discharge from the Army Medical Corps March 6. Captain Garens' first assignment, following his entrance into the Army in October 1942, was Station Hospital, Camp Phillips, Kansas. In June 1943 the doctor was transferred to Regional Hospital, Fort Riley, Kansas, where he served until January 2, 1946. He is a wearer of the American Theater ribbon.

Dr. John A. Grab, who was discharged from the Army in August, has resumed his association in the practice of medicine with **Drs. L. W. Peterson** and **E. J. Nelson** in Sun Prairie. Doctor Grab entered the Army as a major in November 1940. He has recently completed a 12 week refresher course at Percy Jones General Hospital, Fort Custer, Michigan.

L. E. HAUSHALTER

Milwaukee physician, **Captain Lester E. Haushalter**, resumed his civilian practice after being discharged from the Army in January 1946. Captain Haushalter reported for overseas duty in August 1944, serving with the 84th Division in England and Europe until discharged. The doctor entered military service in May 1944.

He is entitled to wear the European Theater of Operations ribbon with stars for the battles of Central Germany, Ardennes, and Rhineland. He was awarded the Bronze Star and the Purple Heart.

After serving in the Army Medical Corps since October 6, 1944, **Captain Charles A. M. Hogben** of Madison received a discharge September 6 and is now with the Mayo Foundation at Rochester, Minnesota. A wearer of the American and Asiatic-Pacific Theater ribbons, Captain Hogben served with the 303d General Hospital on Tinian in the Marianas Islands for eight months, and at Wakeman General Hospital, Camp Atturbury, Indiana.

Milwaukee physician, **Lieutenant Commander Alfred N. E. Merten**, was discharged from the Navy October 23. Since reporting for active duty with the Navy in January 1945, Captain Merten has been stationed at Naval Training Station, Great Lakes, Illinois, and aboard the USS Vestal (AR 4) in the Pacific area with the 3d Fleet at Buckner Bay, South China Sea. A wearer of the Asiatic-Pacific and American Theater ribbons, Commander Merten was awarded the Bronze Star for the Okinawa campaign.

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L. T. KENT

Upon completion of fifteen months of service in the Navy, **Lieutenant Commander Leslie T. Kent** received a discharge and returned to Kenosha to resume his practice. He entered the Navy in February 1945 and was released from active duty May 29, 1946.

Commander Kent was stationed at U. S. Naval Convalescent Hospital, Banning, California; Naval Training Station, Newport, Rhode Island; and aboard the USS Caloosahatchee (A 098) on sea duty on the Atlantic. He is a wearer of the American Theater ribbon.

Major Oscar G. Moland of Augusta had completed almost five years of service as a physician in the Army December 31, 1945 when he received his discharge. Upon reporting for active duty March 10, 1941, Major Moland was assigned to Fort Sam Houston Station Hospital, San Antonio, Texas, for a month. He then served at Carlisle Barracks, Pennsylvania; with the 36th Infantry Division and the 64th Medical Regiment at Camp Bowie, Texas; with the 64th Medical Regiment at Indio, California; and with the 99th Infantry Division at Camp Van Dorn, Mississippi; Camp Maxie, Texas; and in the European Theater.

Major Moland is entitled to wear the American Defense and European Theater ribbons and has stars for the battles of Ardennes, Rhineland, and Central Germany.

Discharged from the Navy in May, **Commander C. F. Park** of Milwaukee has resumed his practice. He went on active duty at the Naval Air Station, Whidby Island, Washington, in October 1943, serving there until March of 1945. Reporting then to Pearl Harbor, Hawaii, the doctor was assigned duty with Naval Hospitals 128, 8, and 10. He returned to this country in March 1946. Commander Park wears the American and Asiatic-Pacific Theater ribbons.

Lieutenant (j.g.) Milton G. Radewan who is now practicing in Wenatchee, received a discharge from the Navy June 14. He was practicing in Madison at the time he went on active duty October 6, 1944.

Lieutenant Radewan, a wearer of the American and Asiatic-Pacific Theater ribbons, served at Shoemaker Naval Hospital, Shoemaker, California; aboard the USS Rawlins (APA 226) in the South Pacific; and at Great Lakes, Illinois.

Major J. K. Tweeten, formerly of De Forest, who entered the service August 12, 1943, at the completion of a year's internship at the Charles T. Miller Hospital in St. Paul, Minnesota, was released from active duty in the Army Medical Corps May 23 and started a practice in Madison. Major Tweeten's military record shows service at the Medical Field Service School, Carlisle Barracks, Pennsylvania, and with the 625th Medical Clearing Company at Camp Breckinridge, Kentucky, in the European Theater, and in Germany with the occupation forces.

Major Tweeten is entitled to wear the American Defense and European Theater of Operations ribbons with three battle stars for Northern France, Rhineland, and Central Europe.

Following over two and one half years of military service, **Captain Bernard P. Waldkirch** of Milwaukee was separated from the Army Medical Corps September 19 and located as a civilian practitioner in De Pere.

The doctor served at Rhoades General Hospital, Utica, New York; the 104th General Hospital, Camp Pickett, Virginia; and the Regional Hospital at Camp Lee, Virginia, before being assigned to the Philippine Islands for duty with the 91st Field Hospital. Later he rendered service with the same field hospital group and with the 128th Station Hospital in Japan.

Captain Waldkirch, who returned to this country in June 1946, is a wearer of the Asiatic-Pacific Theater, Philippine Liberation, Occupation of Japan, and American Theater ribbons with star awards on the Asiatic-Pacific Theater and Philippine Liberation ribbons.

F. E. ZANTOW

Former Madison physician, **Captain Forrest E. Zantow,** was discharged from the Army June 29 and is now practicing in Reeseville. He entered the service in September 1943, serving first with the 105th Medical Battalion, 30th Infantry Division at Camp Forrest, Tennessee, for three months. From February to July of 1944 he was in England and Normandy in action with the 116th Infantry Regiment, 29th Infantry Division.

Upon his return to the United States, the doctor was assigned to Schick General Hospital, Clinton,

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Solids %	11.8	13.3	13.9	13.7	13.4
Protein %	2.63	3.42	3.09	3.91	1.95
Fat %	1.5	0.9	2.1	0.9	0.5
Carbohydrate % by difference	6.4	7.5	7.2	7.6	9.3
Calories per ounce	14	15	17	15	14
Crude Fibre %	0.15	0.29	0.30	0.22	0.43
Calcium %	0.026	0.013	0.046	0.046	0.024
Phosphorus %	0.042	0.065	0.068	0.068	0.051
Iron Mg. per 100 g.	.22	.72	.35	.40	.73
Copper Mg. per 100 g.	.24	.35	.12	.17	.24
Manganese Mg. per 100 g.	.075	.173	.054	.053	.018
Vitamin A—I. U. Per 100 g.	1766	7000	1130	1693	2550
Thiamine Mg. per 100 g.	.018	.080	.036	.037	.069
Riboflavin Mg. per 100 g.	.040	.62	.068	.072	.064
Ascorbic Acid Mg. per 100 g.	1.1	7.3	2.7	3.9	7.5
Niacin Mg. per 100 g.	.77	1.54	1.22	1.29	1.05

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Iowa. A wearer of the European and American Theater ribbons, Captain Zantow was awarded the Distinguished Service Cross and the Purple Heart.

J. P. SCHELBLE

Lieutenant Commander John P. Schelble, Milwaukee, returned to his civilian practice after receiving a discharge from the Navy January 18. When Commander Schelble reported for active duty December 6, 1943, he was assigned to Great Lakes, Illinois, to serve as senior medical officer of Camp Lawrence until June 1944. Subsequently he served at the Precommissioning Training Center, Treasure Island, San Francisco, and for sixteen months aboard the USS Wyandot (AKA 92) as senior medical officer. He wears the Victory Medal, American Theater, Asiatic-Pacific Theater (with one battle star), and the Phillipine Campaign (with one battle star) ribbons.

Recent Releases From Service*

Physicians and Locations	Date Discharged
Bachhuber, A. M., Kaukauna	April, 1946
Bolles, C. S., Green Bay	February, 1946
Calvy, D. W., Fond du Lac	March, 1946
Ceci, G. E., Milwaukee	June, 1946
Cherkasky, Simon, Kaukauna	July, 1946
Earney, L. J., La Crosse	May, 1946
Eisenberg, H. L., Madison	June, 1946
Garens, R. W., Milwaukee	March, 1946
Guzzetta, M. M., Milwaukee	February, 1946
Hildebrand, W. B., Menasha	May, 1946
Katz, H. J., Cedarburg	April, 1946
Kent, L. T., Kenosha	June, 1946
Mendenhall, J. T., Madison	May, 1946
Mokrohajsky, S. M., Green Bay	March, 1946
Park, C. F., Milwaukee	May, 1946
Rankin, F. J., Appleton	May, 1946
Reinardy, A. L., Janesville	February, 1946
Schelble, J. P., Milwaukee	January, 1946
Schilling, R. F., Madison	August, 1946
Schwartz, S. F., Milwaukee	December, 1945
Shapiro, H. H., Madison	May, 1946
Sherman, L. F., Siren	March, 1946
Shimpa, J. F., Milwaukee	March, 1946
Stein, William, Milwaukee	July, 1946
Troxel, J. C., Appleton	April, 1946
Tweeten, J. K., Madison	May, 1946

* Members of the State Society listed in boldface.

Society Proceedings

Outagamie

J. W. HARRIS

The Conway Hotel in Appleton was the scene of the October 17 dinner meeting of the Outagamie County Medical Society. *Dr. John W. Harris,* professor of obstetrics and gynecology at the University of Wisconsin Medical School, Madison, gave a speech entitled, "Recent Trends in Clinical Gynecology," which was followed by a short business meeting including election of officers.

Sheboygan

Dr. Einar Daniels of Milwaukee addressed the members of the Sheboygan County Medical Society at the meeting October 3 at Sheboygan Memorial Hospital. His subject was "Bronchiectasis and Carcinoma of the Lung." *Dr. C. J. Weber,* Sheboygan, reported on the first Cancer Detection Center that was held the preceding week, and brought up the various proposals for discussion that were to go before the House of Delegates when it met in Milwaukee. *Dr. G. J. Hildebrand* discussed the tuberculosis detection program.

Wood

At the September 26 meeting of the Wood County Medical Society held in Marshfield, the following program was presented: "Observations of the Kenney Treatment of Poliomyelitis," *Dr. F. A. Boeckman,* Marshfield; "Erysipeloid and its Treatment with Penicillin," *Dr. Warren L. Macaulay,* Marshfield; "Physiology of the Mucous Membrane of the Nose," *Dr. Lyman A. Copps,* Marshfield; and "The Function of the Red Blood Cell in Health and Disease," Dr. John B. Miale.

Tenth Councilor District

Approximately seventy doctors from Eau Claire and surrounding counties attended the annual meeting of the Tenth Councilor District Medical Society

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September 26 at the Luther Hospital and the Eau Claire Country Club. The morning program at the hospital began with a discussion on amenorrhea by Dr. John McKelvey. At 10 a.m. a symposium on gallbladder diseases was held by *Drs. H. C. Huston* of Eau Claire, James F. Weir and Howard Gray of the Mayo Clinic, Rochester, Minnesota, *D. Murray Angevine*, chairman of the pathology department, University of Wisconsin Medical School, and John McKelvey, chairman of the department of obstetrics and gynecology, University of Minnesota School of Medicine. Doctor McKelvey spoke at a noon session.

Following a luncheon, the afternoon sessions at the Country Club were started with Doctor Angevine speaking on the subject of pathology of joints, tendons, and bursae. Dr. James F. Weir told of some present day concepts concerning liver diseases, and Dr. Howard Gray spoke on surgical management of lesions of the pancreas. Dinner was served at the Country Club.

The committee on arrangements for the meeting included, *Dr. C. B. Hatleberg*, Chippewa Falls, chairman, and *Drs. W. O. Paulson, H. S. Fuson, G. Hoyme, C. H. Falstad, J. W. Tanner, E. P. Hayes*, and *W. R. Manz* of Eau Claire.

Waupaca

H. H. CHRISTOFFERSON

The Waupaca County Medical Society held its September 26 meeting at the Elwood Hotel in New London. *Dr. Albert Graham* of Neenah presented a paper on "Treatment of Genito-Urinary Diseases," and *Dr. H. H. Christofferson* of Colby spoke on "Wisconsin Plan of Insurance."

Fond du Lac

The September meeting of the Fond du Lac County Medical Society was held at the Hotel Retlaw in Fond du Lac September 26. Following a business session, Dr. John Brewer, professor of gynecology at Northwestern University, spoke on the subject "Uterine Myomata."

Milwaukee Neuro-Psychiatric Society

Dr. Franklin G. Ebaugh of the University of Colorado was the guest speaker at the October 21 meeting of the Milwaukee Neuro-psychiatric Society, held at the Marquette Medical School Auditorium. His subject was "Present Day Concepts of Psychoneuroses."

JAMES REGAN

ARTHUR SCHAEFER

Winnebago

The Winnebago County Medical Society met October 3 at the Menasha Hotel in Menasha to hear addresses by two Milwaukee physicians, *Dr. James Regan* and *Dr. Arthur Schaefer*. Doctor Regan's subject was "Fractures and Injuries to the Small Bones," and Doctor Schaefer spoke on "Pediatric Surgery."

Milwaukee Academy of Medicine

The 838th meeting of the Milwaukee Academy of Medicine was held at the University Club of Milwaukee October 15. Following the dinner and business meeting a scientific program was presented with Dr. Lester R. Dragstedt of the department of surgery, University of Chicago, speaking on "Surgical Treatment of Peptic Ulcer."

Milwaukee Oto-Ophthalmic Society

The Milwaukee Oto-Ophthalmic Society met on Tuesday, October 22 at the Milwaukee Athletic Club. The following scientific program was presented: "Pulsating Exophthalmos, Presentation of a Case," *Dr. Edward Waldeck*, Milwaukee; and "Practice of Otolaryngology in Mexico City," Dr. Walter Reinking.

La Crosse

At the Stoddard Hotel, La Crosse, October 15, members of the La Crosse County Medical Society gathered for dinner and a talk entitled "Application of Methods of Treatment of Infections War Wounds to Civilian Types of Extremity Infections," presented by the speaker of the evening, Dr. Ed. Evans of Minneapolis.

STATE BOARD OF MEDICAL EXAMINERS

At this time the board is preparing the files for annual registration. All doctors returning from service and any others who have not completed the original registration application should contact the State Board of Medical Examiner's office immediately in order to be included in the 1947 registry.

As Appetite Declines

WITH THE YEARS

The many somatic and emotional changes encountered in senescence are manifested in a variety of ways, especially by a decrease in appetite. Reduced energy expenditure, atrophic gastric changes, exaggerated food dislikes, and food intolerance all contribute, and not infrequently lead to a state of undernutrition. In older patients, this chain of events can easily produce excessive weakness and impaired stamina, adding to the burdens of senility.

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*Based on average reported values for milk.

AND ABOUT THE THIRD DISTRICT:

"With a marked concentration of physicians in the Third Councilor District, the *Journal* is assembling all news items pertaining to activities of physicians in Dane, Rock, Green, Columbia, Sauk, Marquette and Adams Counties and presents them together. The *Journal* urges county secretaries to send personal items of interest. Such notices should reach our office by or before the fifteenth of each month before publication."

—EDITOR'S NOTE

SOCIETY PROCEEDINGS

Dane

C. M. KURTZ

The Dane County Medical Society held its regular monthly meeting at the Madison Club, Madison, October 15. The annual business meeting, with reports and election of officers, was followed by a speech by *Dr. Chester M. Kurtz*, associate professor of clinical medicine, and head of the department of cardiology at the University of Wisconsin, Madison. Doctor Kurtz' subject was, "The Newer Isolated Principles of Digitalis." *Dr. John K. Curtis* of Madison discussed the paper. Members of the board of trustees met earlier in the evening.

Rock

Dr. Fred Welch, Janesville city health officer, was the guest speaker at the September 24 dinner meeting of the Rock County Medical Society held at the Cabot Grill in Beloit. Doctor Welch who was introduced by *Dr. Joseph Springberg*, Beloit health officer, talked on "Polio—What We Know About It and What We Can Do About It."

University of Wisconsin Medical Society

The first of the 1946–1947 series of meetings of the University of Wisconsin Medical Society was held October 15 in the auditorium of the Service Memorial Institutes, Madison. The program, presented by members of the staff of the McArdle Memorial Laboratory, was as follows: "Research Projects at the McArdle Memorial Laboratory," Harold P. Rusch, M. D.; "The Present Status of Research on the Hepatic," James A. Miller, Ph.D.; and "Carcinogen p-Dimethylaminoazobenzene," Elizabeth C. Miller, Ph.D.

COUNCILOR DISTRICT NEWS

New Director, McArdle Memorial Laboratory

A recent announcement by the Board of Regents of the University of Wisconsin and *Dr. William S. Middleton*, dean of the University Medical School, reveals that Dr. Harold P. Rusch of Madison has been appointed director of the McArdle Memorial Laboratory for Cancer Research.

Doctor Rusch, who will continue as professor of oncology, has been engaged in cancer research since July of 1935 when he was appointed a Jonathan Bowman Memorial Fund Fellow and Research Fellow in Cancer.

Dr. Myra Burke Returns to Madison

Dr. Myra E. Burke, former Madison general practitioner and physician for the state girls' school at Oregon, has returned to Madison to be associated with her husband, *Dr. Mead Burke*, in the diagnosis and treatment of allergic conditions. Since May of this year, Dr. Myra Burke has been doing special work at the asthma and hay fever clinic in Cleveland, Ohio, where emphasis was placed on allergic conditions of infants and children.

University Staff Appointments

Dr. C. Knight Aldrich, formerly of Winnetka, Illinois, has recently been appointed assistant professor of neuropsychiatry in the department of student health at the University of Wisconsin, Madison. Doctor Aldrich graduated from the Northwestern University Medical School, Chicago, in 1939. He was resident physician in neuropsychiatry at the U. S. Marine Hospital at Ellis Island, and then became associated with the U. S. Public Health Service serving in this country and with military groups in the Pacific area.

Dr. John W. Brown of the University of California Medical School and Hospital, has been appointed to the post of professor of preventive medicine and director of the department of student health at the University. Doctor Brown's appointment will become effective November 1. The doctor, who received his M. D. degree from the University of California Medical School in Berkeley and San Francisco, in 1935, was on a war leave from that institution from

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November of 1941 to December 1945. A native of Iowa, Doctor Brown is certified by the American Board of Internal Medicine.

SOCIETY RECORDS

New Members

Allen G. Johnson, Schultz Building, Rice Lake.

Russell S. Pelton, Markesan.

Bernard J. Werra, Milwaukee County Hospital, Wauwatosa.

Daniel M. Clark, Strongs Building, Beloit.

George Malin, 1404 Main Street, La Crosse.

Frederick W. Henke, 137½ South Main Street, Shawano.

Herman L. Eisenberg, 313 North Frances Street, Madison.

Otto A. Dittmer, Jr., 217 North Orchard Street, Madison.

Leonard A. Gay, 1501 Vilas Avenue, Madison.

Edwin R. Orr, 1209 Sherman Avenue, South Milwaukee.

D. Murray Angevine, 426 North Charter Street, Madison.

Abner P. Bennett, 1300 University Avenue, Madison.

John T. McCoy, 1300 University Avenue, Madison.

Clayton P. Wangeman, 1300 University Avenue, Madison.

Harold C. Youngreen, 1300 University Avenue, Madison.

John B. Balken, Chetek.

Robert L. Schwab, Marion.

Henry Santina, 316 South State Street, Waupaca.

Richard M. Block, 520 Fifty-eighth Street, Kenosha.

John G. Russo, Riverview Sanatorium, Kaukauna.

James E. Gmeiner, Zuelke Building, Appleton.

George A. Behnke, 240 West Wisconsin Avenue, Kaukauna.

Philip W. Smith, Black Creek.

Edward K. Steinkopff, Pinehurst Sanatarium, Janesville.

John F. Holmes, Milton Junction.

Herbert A. Dasler, Lake Mills.

William F. Janc, 206½ Bridge Street, Chippewa Falls.

Verne C. Epley, 229 South Michigan, Prairie du Chien.

Symphorian F. Brusky, Pulaski.

Russell F. Lewis, Jr., 411 South Maple Street, Marshfield.

Warren L. Macaulay, Marshfield Clinic, Marshfield.

Lewis J. Weller, Osceola.

Arnold H. Hohf, Milltown.

John C. McCullough, Devine Clinic, Fond du Lac.

Judd D. Fuller, Lomira.

Ronald W. Steube, St. Agnes Hospital, Fond du Lac.

Louis C. Orban, Veterans Hospital, Wood.

George F. Crikelair, 401½ Main Street, Stevens Point.

Harris A. Weisse, New Holstein.

James F. Hildebrand, 2220 North Seventh Street, Sheboygan.

Changes in Address

F. E. Zantow, Madison, to State Bank Building, Reeseville.

R. C. Beardsley, Madison, to 1108 Maple Avenue, Zanesville, Ohio.

M. W. Meyer, Vero Beach, Florida, to 1 West Wilson Street, Madison.

R. W. Beck, Milwaukee, to 227 Urquhart Building, Little Rock, Arkansas.

Simon Cherkasky, Appleton, to Kaukauna.

J. R. Goodfellow, Superior, to Deerpath Road, R.F.D. 5, Aurora, Illinois.

Emma D. Kyhos, Madison, to Hoffman–LaRoche Company, Nutley 10, New Jersey.

Will G. Merrill, Washburn, to Box 125, Ashland.

J. A. Carswell, Janesville, to Veterans Administration Hospital, Walla Walla, Washington.

J. S. Feurig, Green Bay, to 7505 West Garfield Avenue, Milwaukee.

J. A. Grab, Madison, to Sun Prairie.

J. J. Farrell, Galesburg, Illinois, to Albany Hospital, Albany 1, New York.

D. W. Calvy, Fond du Lac, to 2441 South Nineteenth Street, Milwaukee.

J. W. Temple, Fond du Lac, to 4133 South Howell Avenue, Milwaukee.

D. E. Mings, Madison, to 1684 North Prospect, Milwaukee.

C. H. Feasler, Big Pine, California, to Rogers Memorial Sanitarium, Oconomowoc.

L. L. Swan, Bagley, to Army Institute of Pathology, Seventh and Independence, S. W., Washington 25, D. C.

C. W. Stoops, Ann Arbor, Michigan, to Department of Dermatology, Veterans Hospital, Wood.

R. G. Mayer, Wood, to 113 East Fifth Street, Kaukauna.

William Stein, Wood, to 161 West Wisconsin Avenue, Milwaukee.

Chester Wade, Oconomowoc, to 263 Columbia, Elmhurst, Illinois.

A. J. Wagner, Chicago, to 508 West Milwaukee Street, Janesville.

G. E. Ceci, Wood, to 161 West Wisconsin Avenue, Milwaukee.

G. R. Hammes, Seneca, to 818 Fulton, Wausau.

J. F. Shimpa, Blue River, to Veterans Administration Hospital, Cheyenne, Wyoming.

J. M. Schroeder, Milwaukee, to Vulcan, Michigan.

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**N. Y. State Journ. Med. 35 No. 11,590*
Laryngoscope 1935, XLV, No. 2, 149-154

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DEATHS

Dr. Bernard L. Cleary, 76, a physician in Edgerton for the past forty-six years, died Saturday, September 21 at an Edgerton hospital. He had been in failing health for some time.

Doctor Cleary was born in North Bristol, Wisconsin, in 1870. He attended the Stoughton Academy, and after graduating from Rush Medical College in Chicago with the class of 1900, started his practice in Edgerton.

A former member of the Rock County Medical Society, he also formerly held membership in the State Medical Society, the American Medical Association, and the American Railway Physicians and Surgeons.

Surviving Doctor Cleary are a son and two daughters.

Dr. Joseph F. Kenney of Milwaukee, medical specialist at the Veterans Administration's Milwaukee regional office, died at his home Wednesday, September 18. He was 60 years old.

A native of Delavan, Doctor Kenney was graduated from Milwaukee Medical College in 1908. He practiced medicine in Benton before moving to Milwaukee about fifteen years ago. Doctor Kenney joined the Veterans Administration in 1942.

The doctor was a former member of the Lafayette County Medical Society, the State Medical Society, and the American Medical Association.

He is survived by his wife and two sons, both recently discharged from the Army.

News Items and Personals

Wisconsin Association of Medical Technologists

O. O. MEYER

Meeting in Madison at the Jackson Clinic and St. Mary's Hospital, October 19 and 20, the Madison Chapter of the Wisconsin Association of Medical Technologists was host to the society at their annual state convention.

The section of the program with speakers was as follows: "Theory of Photometry," Joseph G. Beyer, Ph.D., of the Wisconsin Extension Division, Milwaukee; "The Factors Influencing the Cultivation of the Tubercle Bacillus from Gastric Juice," *Dr. E. A. Birge,* assistant professor of pathology, University of Wisconsin, Madison; and "Some Aspects of the Hemorrhagic Diseases," *Dr. O. O. Meyer,* professor of medicine, University of Wisconsin. *Dr. J. S. Supernaw* of Madison was the speaker at the dinner held at the Nakoma Country Club.

—△—

Doctor Ansfield Resumes Practice

Glidden, Wisconsin welcomed back *Dr. F. J. Ansfield* the last part of September when he returned to that community after an absence of four years and took over from Dr. K. W. Baker who had been temporarily located there.

Doctor Ansfield left Glidden for Army service in 1942, and after participating in campaigns in the Pacific, was discharged late last year. Since then he has been taking a postgraduate course in medicine at the University of Wisconsin Medical School. Doctor Baker has moved to Turtle Lake where he will locate permanently.

—△—

Golf Tournament

Dr. P. J. Purtell of Milwaukee again won the championship of the Wisconsin State Medical Golf Association at the annual tournament October 8 at North Hills Country Club, Milwaukee. *Dr. E. L. Watson,* Ripon, scored for second place, and *Dr. Harry Maxwell* of Milwaukee, third.

The Summit tournament will be held in Fond du Lac with *Dr. J. C. Devine* of Fond du Lac in charge of arrangements.

—△—

Doctor Plahner is Speaker

"Why People Act the Way They Do," was the subject of a lecture by *Dr. Samuel Plahner* of Milwaukee, consulting psychologist and psychiatrist, at a meeting of the Junior Auxiliary of Deaconess Hospital, Milwaukee, October 2, at the hospital.

Doctor Plahner also spoke October 3, at the Ambassador Hotel, Milwaukee, to members of the Junior Savings and Loan League on "Psychology Applied in Business."

—△—

Doctor Sanford Moves to Hillsboro

Dr. L. L. Sanford of Milwaukee moved to Hillsboro the last part of September and occupied the offices of Dr. R. S. McKetchnie who died August 7. Doctor Sanford, who is a graduate of the University of Wisconsin Medical School, has recently been a consultant for the Deans Committee of the Marquette University School of Medicine in Milwaukee. He is also a member of the consulting staff of physicians at the Veterans Hospital at Wood, Wis.

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Postgraduate Course Offered

F. D. MURPHY

A four week postgraduate course in internal medicine, held at the Milwaukee County General Hospital, was started October 28. Designed especially for the physician who has returned from military service, the course is also aimed at giving the doctor who stayed at home an opportunity to gain knowledge on newer aspects. It is sponsored by the Marquette University School of Medicine under the direction of *Dr. Francis D. Murphy,* director of the school's department of internal medicine, and medical director of the hospital.

—△—

Dr. P. K. Doege Receives Degree

Dr. Paul K. Doege of the Marshfield Clinic, Marshfield, received a degree and diploma from the International College of Surgeons, to which he was admitted with the rank of fellow, at the convocation, October 22, at the Masonic Temple in Detroit. The doctor went to Detroit to attend the eleventh assembly of the United States chapter of the College held October 21, 22, and 23.

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(ORGANIZED 1929)

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Eighteenth Annual Meeting of Auxiliary

Mrs. Aldace W. Hammond, Beaver Dam, Named President-Elect

IF YOU attended the Eighteenth Annual Meeting of our Woman's Auxiliary to the State Medical Society, held October 6, 7 and 8, 1946, you had, I am sure the realization that our Auxiliary members are actively engaged in carrying out their obligations as doctors' wives and planning a postwar health program for our state.

The Sunday evening Board of Directors' dinner was a momentous occasion at which our president, Mrs. Arthur J. McCarey, presided. We were greatly impressed by her address of welcome and the preconvention ceremony in honor of the eighteen past-presidents of our Auxiliary.

Surrounding the beautifully decorated cake were eighteen white candles, and during the ceremony a candle was lighted honoring the year of service of each past president, one of which was in memory of Mrs. F. Gregory Connell (deceased).

The special guest of the evening was Mrs. Jesse D. Hamer of Phoenix, Arizona, national president of the Auxiliary to the American Medical Association, who brought us a message of hope and confidence in our new undertaking and a renewal of a pledge of loyalty to the American Medical Association.

The convention carried us through a whirl of events which included general meetings, luncheons, and a buffet supper, and concluded with the informal banquet of the State Medical Society.

At the Monday morning general meeting, reports of the state president, state committee chairmen, and county auxiliary presidents were presented, each having carried on her duties in spite of extra burdens during this adjustment period. Of special interest and inspiration was the talk given by Mrs. Hamer in presenting her message from the American Medical Association.

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New officers were installed on Tuesday morning and Mrs. McCarey graciously presented her gavel to Mrs. J. C. Fox, new state president, to whom we extend our best wishes, and also to her officers, in the discharge of their official duties during the coming year.

Words can hardly express the gratitude we owe to Mrs. William Liefert and her wonderful committee for the success of the Eighteenth Annual Meeting: the excellent talent provided for at the social gatherings, the beautiful floral arrangements, and last but not least, food to satisfy epicurean taste.

May we all meet at the 1947 annual meeting.

MRS. G. J. PUGH,
Publicity Chairman.

Report of the 1945-1946 Auxiliary President*

By MRS. ARTHUR J. McCAREY
Green Bay

Mrs. Arthur J. McCarey
Green Bay
President
1945–1946

IT IS a privilege to welcome you to the Eighteenth Annual Meeting of the Woman's Auxiliary to the State Medical Society of Wisconsin. It makes me very happy to see so many faces that we have known in the past, and I especially wish to welcome those of you who are new to our organization. I bid you all welcome — a very sincere and heartfelt welcome today.

Recalling the words of our national president, Mrs. David Thomas, who said that "Life is but a moment between eternities," it seems but a moment —the passing of a day—yet Time reveals this is the report of my year of service and that this year is almost at a close.

The summary of my report will be as brief as possible. I am not going to tell you how many letters I have written, nor how much time I have spent in carrying out the duties as your president, but I am going to say that the reports of my chairmen that you will soon hear will demonstrate that *they* should be accredited with the year's accomplishments. I have been their servant and yours.

The past year has shown a united front — a marvelous spirit of cooperation and service. It has been a rare privilege to have served with such a group. They have given me encouragement to carry out the obligations of my duties, which our work entails if we are to further the ideals of the medical profession.

At this time too, I should like to pay homage to our leaders in the past, who have been women of integrity and purpose. They have shown us the way and we have gathered from their past experiences those things which have served as steppingstones.

The National Conference was attended in Chicago in December. It was an occasion of special significance. I brought home from that meeting a resolution that was passed by the House of Delegates of the American Medical Association. *That resolution* became my *theme song* for the year. It was a challenge given by our parent organization, when it requested the Woman's Auxiliary "to use every avenue possible to bring knowledge concerning the hazards of current medical legislation to its members and through them to the public." I knew then that we had ahead of us a year or two in which a fight to the finish on the question of *compulsory* health insurance was inevitable. It was urgent to begin at once to work out a program in order to carry out those wishes of the American Medical Association. Immediately we mapped out our campaign.

I am happy to record the untiring efforts of our State Public Relations Chairmen, and our other state chairmen, who not only promoted their own committee plan of work, but without exception *also* adopted our state program for *study* of medical legislation. They all worked together in friendliness and mutual understanding. They proved that they knew what was meant by one particular object in our Constitution of the Woman's Auxiliary where it refers to encouragement of kindly social relationships and promotion of mutual understanding among physicians' families. I am *proud* of our medical women and I take this opportunity to tell them so.

I have visited a number of the county groups during the year and only wish that it had been possible to accept all of the friendly invitations extended to me. Those that I visited were a pleasure and an inspiration.

* Presented before the Eighteenth Annual Meeting of the Woman's Auxiliary to the State Medical Society of Wisconsin, Milwaukee, October, 1946.

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The **Page**

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Our midyear meeting was an occasion to remember. *Never* can I recall such fortitude exacted from the members of the executive board. The meeting convened at 1:30 p. m. and adjourned at 6:00 p. m. Thirty-six members were present, including six of the past state presidents, who were honored guests. It was a most stimulating meeting. A midyear report of that meeting was compiled and sent to all county presidents, officers, and chairmen of all state committees, and likewise to the past state presidents.

I have appreciated the fine suggestions sent by the national officers, and by Margaret Wolfe in the Central Office, Chicago. I also wish to express my appreciation to Dr. S. E. Gavin, chairman of our Advisory Council; to Dr. P. R. Minahan, president of the State Medical Society; and to Mr. C. H. Crownhart of the State Medical Society Office in Madison, for their encouragement and help.

No new counties were organized this year but memberships at large were encouraged, with the future hope that additional counties would be organized later. Renewed interest in some counties was apparent.

Biographical data and photographs of our pioneer physicians have also been collected and written in our Auxiliary Archives, thus adding to the record of events in the history of our medical society.

Auxiliary Handbooks and the August Bulletin were purchased and given out with the State Constitution to every officer and committee chairman to better acquaint them with the duties of their respective committees. These were distributed at the Post-Convention Board meeting.

Immediately after the Convention last October, typed lists of state officers, chairmen of committees, and names of county presidents were sent to the national and state officers. Plans were formulated for the year's work and were carried through without delay by the committee chairmen.

Tentative plans for publicity were submitted and accepted by *The Wisconsin Medical Journal* for the inclusion of pictures of state officers and committee chairmen. Two articles were requested: one to present their plan of work for their particular committee, and another one listing some of their former activities in both civic as well as auxiliary work. These articles have received much favorable national comment and gave the membership at large a more intimate picture of the women of the state who were devoting so much time to the Auxiliary affairs. We deeply appreciate the space given our Auxiliary for this and also for the items of interest each month sent in from the county auxiliary groups of their activities.

Last December I was a guest of the Milwaukee County Auxiliary. It was a delightful holiday occasion and I thoroughly enjoyed the gracious hospitality and the many courtesies extended to me at that time.

Fond du Lac, Outagamie, Winnebago, and La Crosse were visited in the spring and there also the same gracious hospitality was extended to me by their members.

Wisconsin's report of her various county activities was written and sent to the national president at the appointed time in April.

The National Convention in San Francisco was attended in July, and as Wisconsin's representative, your president reported on the year's accomplishments to the other state delegates. That convention proved to be another most noteworthy event as the House of Delegates of the American Medical Association passed, at that time, a resolution and presented it to the Woman's Auxiliary. It complimented and acknowledged the past efforts and accomplishments of the Auxiliary and urged its continued efforts in public relations work. The House of Delegates emphasized the fact that it would meet with and assist the Auxiliary in its efforts. In this way it felt that a tremendous power would be created that would be effective in public relations work.

As we are about to enter another year of Auxiliary service we are faced with the same fears in regard to the ideals and basic rights of American medicine. We must continue our drive toward intelligent publicity and education as to the purpose and accomplishments of American medicine. May I again solicit your continued support of this program in the interests of the medical profession. Good human relationships like good health cannot be maintained by a passive attitude; they require constructive activity. They need the vigilance and leadership of every member of the Woman's Auxiliary to the American Medical Association.

And now that I am about to relinquish my duties as president, many happy memories linger. Even though my tasks were sometimes difficult, and many hours were given to this service, I shall always cherish and remember the pleasant experiences (of which there were many) and be grateful that I was able to serve the Woman's Auxiliary.

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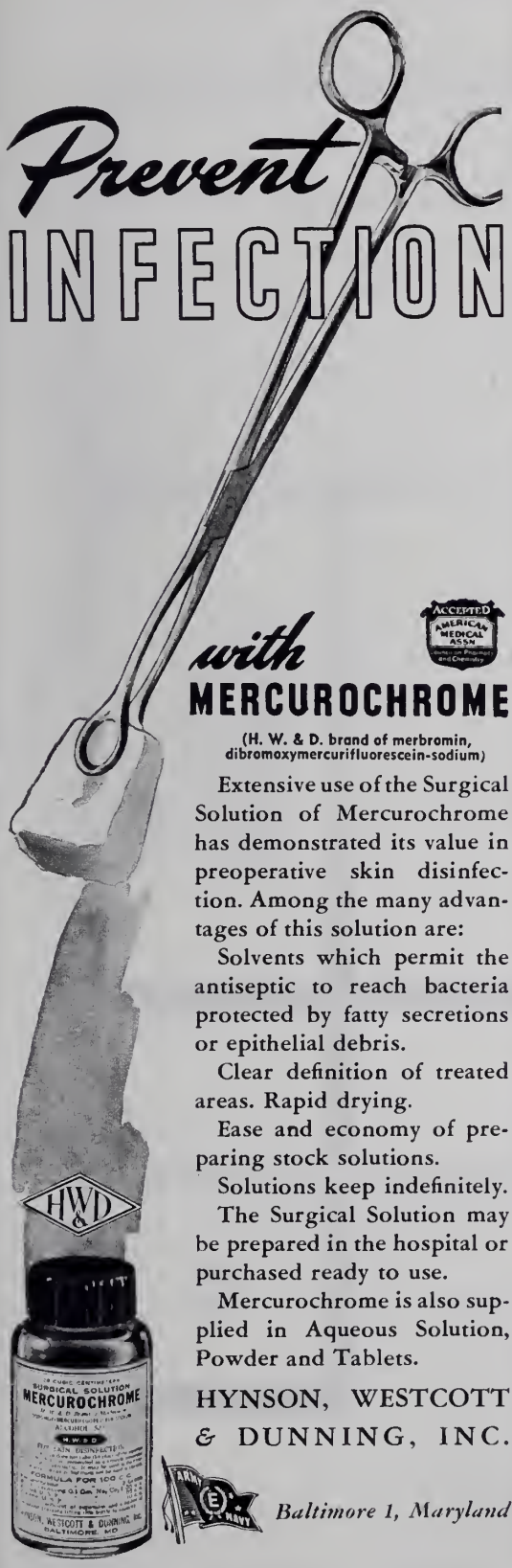

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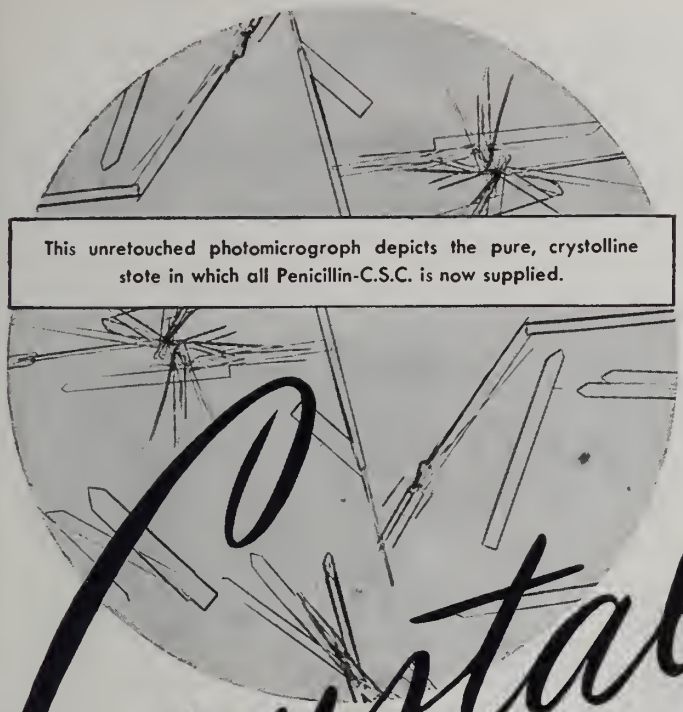

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Crystalline Penicillin Sodium-C.S.C. is available in serum-type vials containing 100,000, 200,000, or 500,000 units.

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(Continued from page 1061)

D. *Urobilinogen Estimations on Stool and Urine Specimens.* These determinations with the Watson method are extremely useful in the detection of hepatic dysfunction and in the differential diagnosis of jaundice.

See the article in this column of *The Wisconsin Medical Journal* for August 1946.—W. H. JAESCHKE, M. D., *University of Wisconsin.*

ERYSIPELOID—MACAULAY

(Continued from page 1059)

8. Klauder, J. V., and Rule, A. M.: Sulfonamide compounds in treatment of erysipelothrix rhusiopathiae infections; effectiveness of sulfanilamide, sulfapyridine, sulfathiazole and sulfadiazine against experimental infection in mouse and against erysipeloid of Rosenbach in man, Arch. Dermat. & Syph. 49:27–32 (Jan.) 1944.
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11. Nicholas, L.: Erysipeloid: successful treatment with penicillin, Arch. Dermat. & Syph. 54:57–59 (July) 1946.

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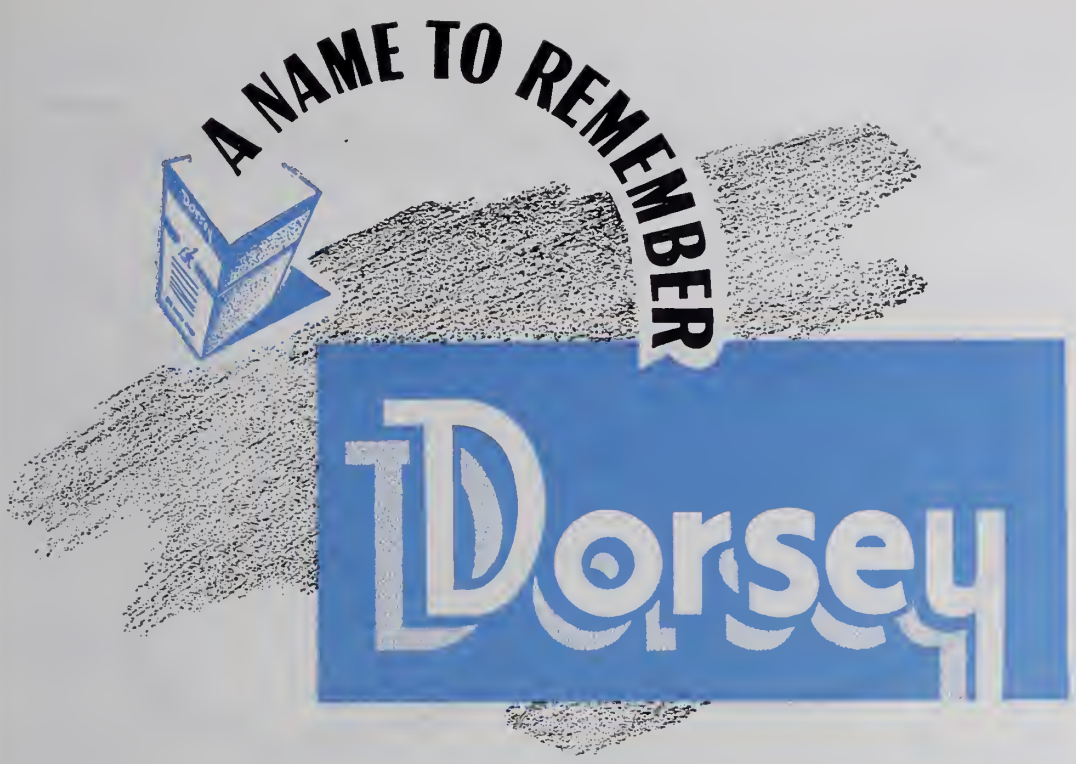

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1. Am. J. Surg. 44:288 (April) 1942.

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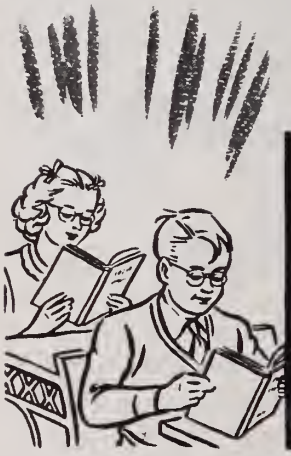

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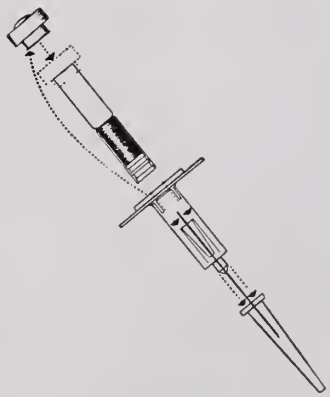

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FOR SALE: Picker-Waite Shock Proof modern 200 KV X-ray machine, with complete dark room equipment, $4,500. 1936 model Jones Metabolism machine, $200. Cold Quartz Ultra Violet machine with timer, $100. Address replies to No. 61 in care of the Journal.

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WANTED: Young surgeon age 33 with three and a half years residency experience desires association or affiliation for general surgery board credit. Desire location with a view of permanency. Opportunity for operation experience more important than financial consideration. Address replies to No. 76 in care of the Journal.

WANTED: Young or middle-aged physician with ability to do general surgery to join hospital staff in city of 50,000 in western Wisconsin. Opening gives physician excellent opportunity to attain large scale practice in reasonably short time. Wisconsin license required. Give qualifications. Address replies to No. 71 in care of the Journal.

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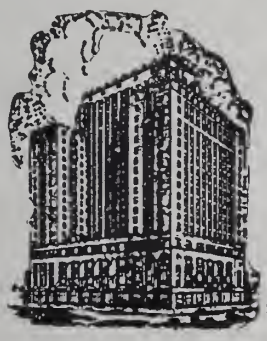

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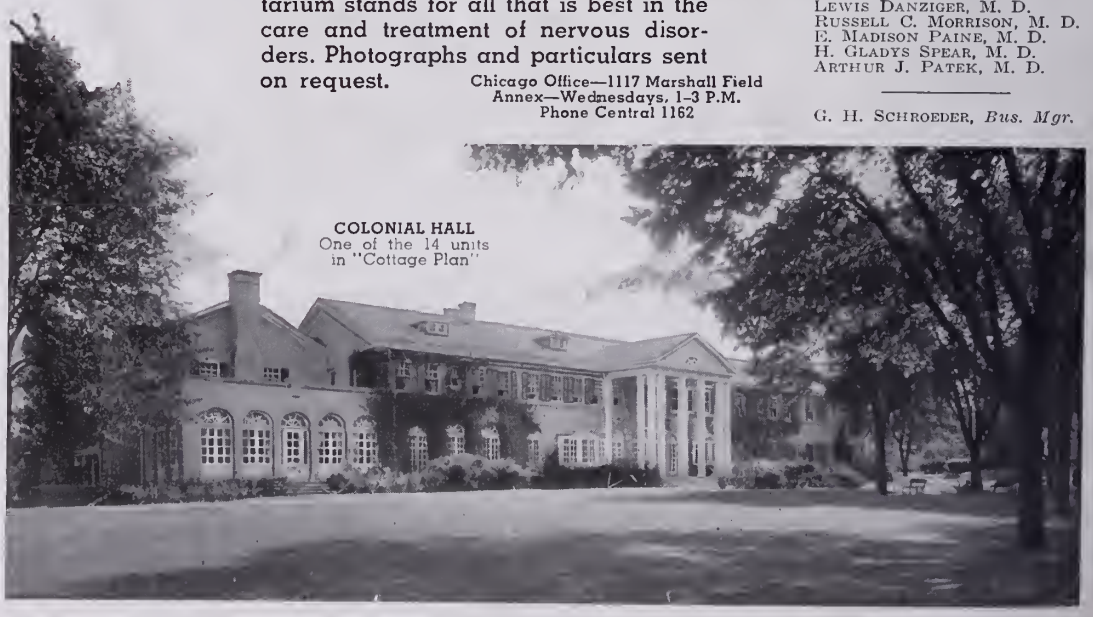

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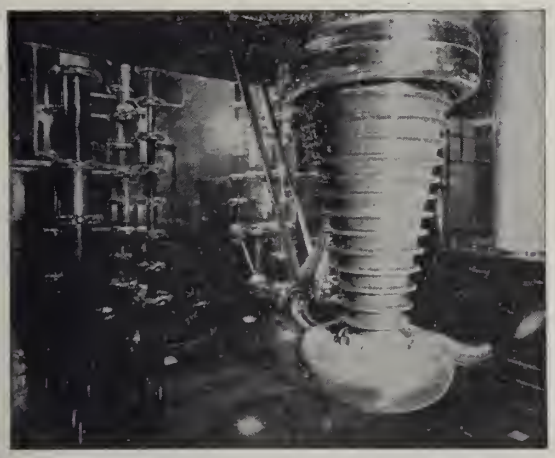

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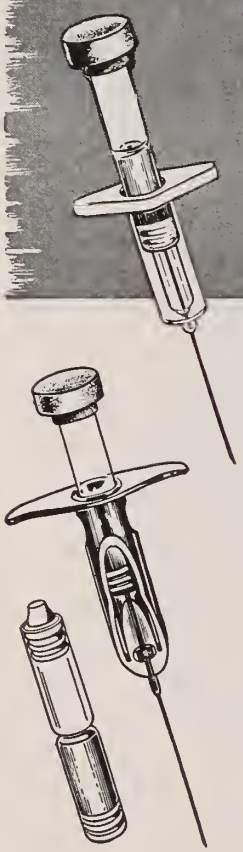

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3. Sahyun, M.: *Am. J. Dig. Dis.*, 13:59, 1946.

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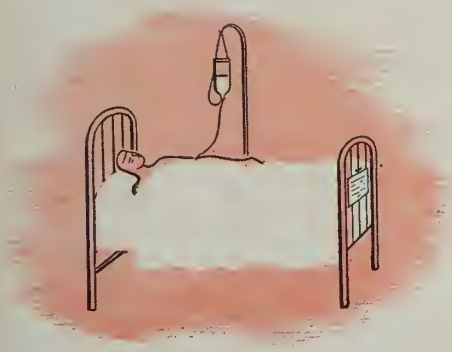

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Erickson, T. C., Masten, M. G., and Gilson, W. E. (1946), Observations on the Use of Tridione in the Treatment of Epilepsy, Presented before Amer. Neurological Soc., San Francisco, June.

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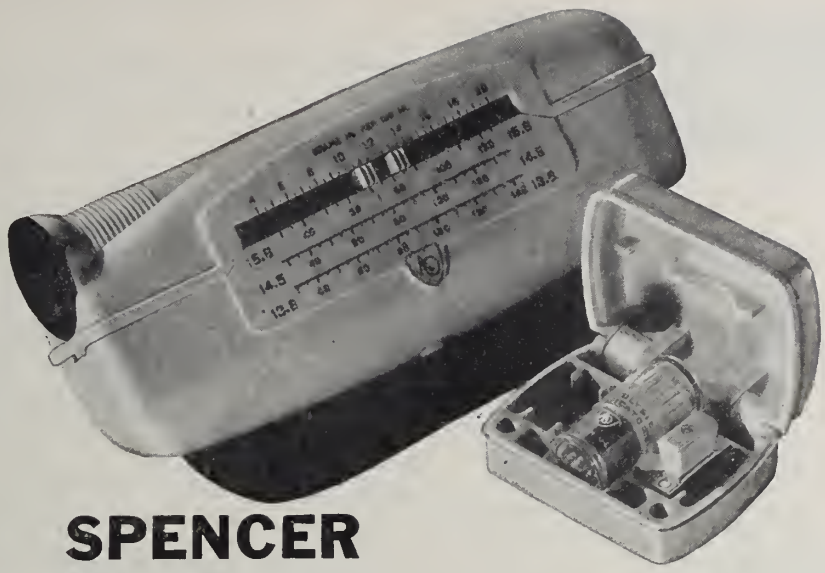

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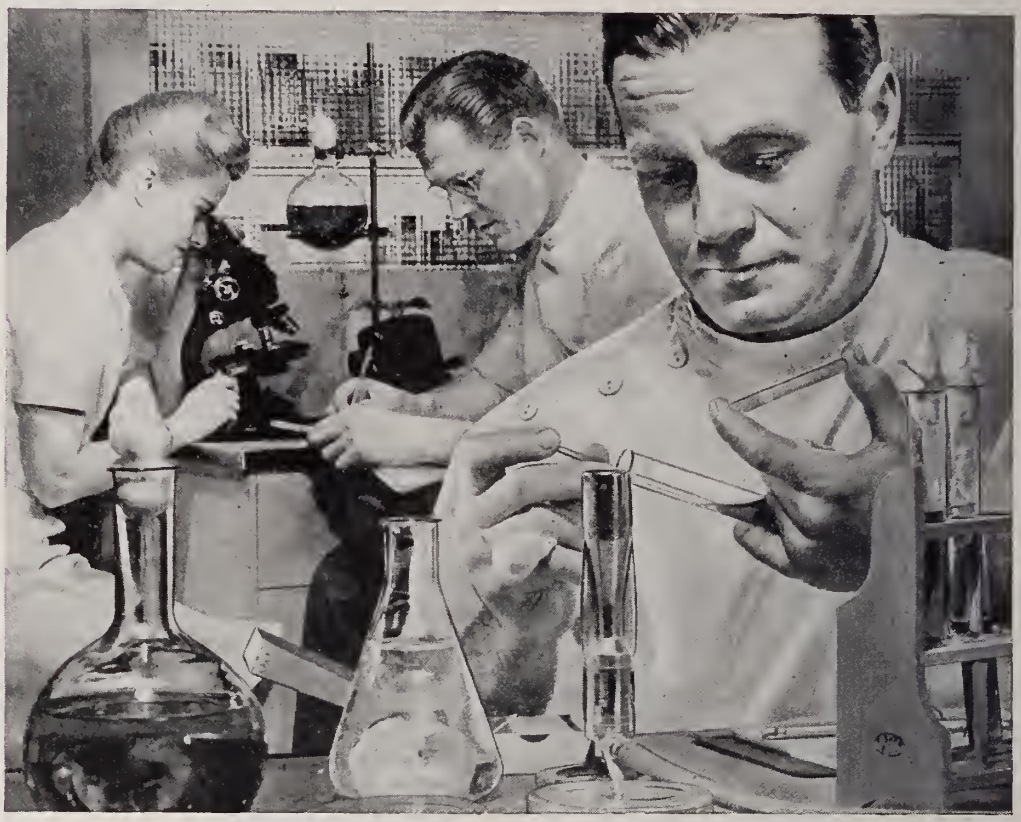

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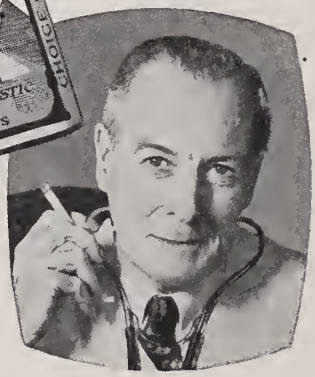

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The Reversibility of Hypertensive Heart Disease by Lumbodorsal Sympathectomy*

By PAUL D. WHITE, M. D.
Boston

P. D. WHITE

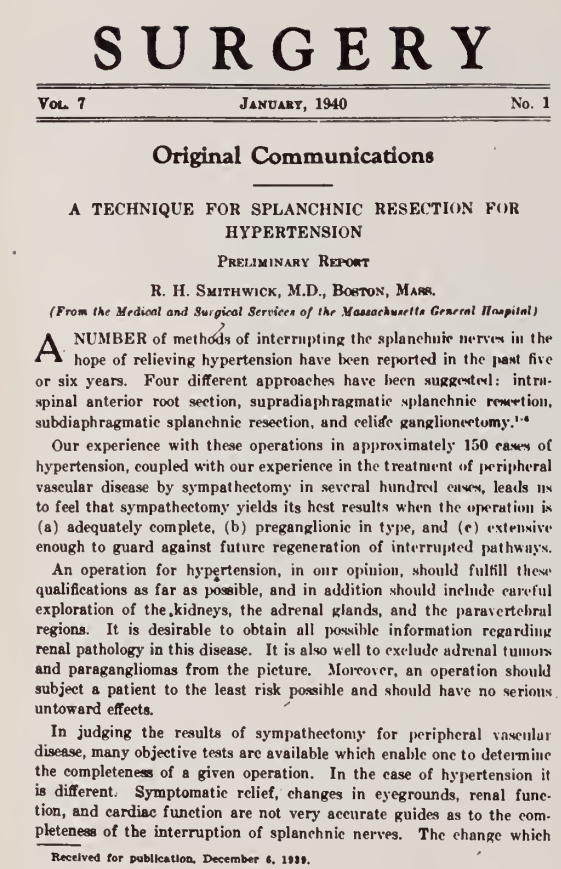
Doctor White graduated from Harvard Medical School, Boston. As a Harvard travelling fellow he studied in London and Vienna. The doctor, who is now clinical professor of medicine at Harvard Medical School, has served as resident in medicine at Massachusetts General Hospital, and as teaching fellow at Harvard. He is active in many medical groups and societies.

ONE of the most interesting and dramatic experiences of my medical career has been my observation during the past few years of the specific treatment of essential hypertension by surgery, with the consequent proof of the reversibility of heart disease in many of the cases encountered. My experience of some twenty years previously had resulted in a very pessimistic outlook for patients whose hearts were seriously affected by hypertensive heart disease even though uncomplicated by other factors. The best one could do was to delay somewhat the downhill progress of the disease by the measures available, which included rest, reducing diets, and certain drugs such as sedatives and the thiocyanates. By the time heart failure developed, which is the most common terminal complication of serious hypertension, all that was left was the treatment of the heart failure by the usual methods at our disposal.

Early in 1942, four years ago, in large part as the result of the war, I was obliged to resume many routine tasks covered during the previous few years by my younger associates who had then been called off to military service. Due to this I began to note surprising changes for the better in the electrocardiograms of hypertensive patients over a period of months or years, something I had not previously encountered and which one does not see ordinarily in the course of the downhill progression of hypertensive cardiac cases. When I investigated these particular records I found that they always belonged to patients who had been operated upon by one of my surgical associates at the Massachusetts General Hospital, Dr. Reginald Smithwick. It was natural for me then to inquire in particular about the kind of surgery that he was doing, although we all knew that he was carrying on some procedure of sympathectomy in therapy. I learned that in 1939 he had introduced a new technic, the description of which was published in January 1940 in *Surgery* (see fig. 1.) He had more or less combined the often inadequate technics of subdiaphragmatic and of supradiaphragmatic sympathectomy. Incidentally, he always explored the adrenal glands and kidneys and obtained, at the time of operation, biopsies of both kidneys. The operation carried out from the back has been done first on one side, the right, and after ten days to two weeks on the other side (fig. 2.)

During the past four years I have closely followed Doctor Smithwick's surgical therapy and we have been associated in the study and treatment of many cases. At first there had been a general avoidance of the more

* Presented before the One Hundred Fifth Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, October, 1946.



SURGERY

Vol. 7 January, 1940 No. 1

Original Communications

A TECHNIQUE FOR SPLANCHNIC RESECTION FOR HYPERTENSION

Preliminary Report

R. H. Smithwick, M.D., Boston, Mass.
(From the Medical and Surgical Services of the Massachusetts General Hospital)

A NUMBER of methods of interrupting the splanchnic nerves in the hope of relieving hypertension have been reported in the past five or six years. Four different approaches have been suggested: intraspinal anterior root section, supradiaphragmatic splanchnic resection, subdiaphragmatic splanchnic resection, and celiac ganglionectomy.[1-6]

Our experience with these operations in approximately 150 cases of hypertension, coupled with our experience in the treatment of peripheral vascular disease by sympathectomy in several hundred cases, leads us to feel that sympathectomy yields its best results when the operation is (a) adequately complete, (b) preganglionic in type, and (c) extensive enough to guard against future regeneration of interrupted pathways.

An operation for hypertension, in our opinion, should fulfill these qualifications as far as possible, and in addition should include careful exploration of the kidneys, the adrenal glands, and the paravertebral regions. It is desirable to obtain all possible information regarding renal pathology in this disease. It is also well to exclude adrenal tumors and paragangliomas from the picture. Moreover, an operation should subject a patient to the least risk possible and should have no serious untoward effects.

In judging the results of sympathectomy for peripheral vascular disease, many objective tests are available which enable one to determine the completeness of a given operation. In the case of hypertension it is different. Symptomatic relief, changes in eyegrounds, renal function, and cardiac function are not very accurate guides as to the completeness of the interruption of splanchnic nerves. The change which

Received for publication, December 6, 1939.

Fig. 1.—Title page of Doctor Smithwick's paper on lumbodorsal sympathectomy for hypertension.

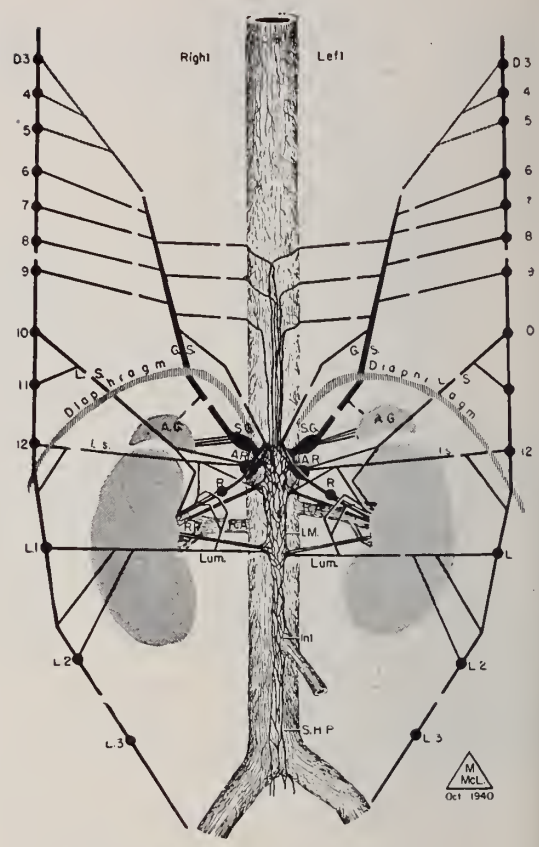


Fig. 2.—Diagram showing the position of the nerves cuts (from Smithwick.)

seriously affected patients, that is, those with important degrees of renal or cardiac disease. Patients with renal insufficiency have continued to be poor subjects in general for the operation—with greater risks and less likelihood of improvement. But cardiac patients have stood the operation surprisingly well as a rule and have, as a result of the reduction of the pressure, often shown a marked improvement of the heart trouble itself. Patients who have had cerebral vascular accidents have also usually stood the operation very well, with a reduction of pressure in the majority of cases.

The reversibility of hypertensive heart disease demonstrated during the past few years by this surgical procedure of lumbodorsal sympathectomy in the hands of Doctor Smithwick has been a crowning achievement in a long series of demonstrations of the reversibility of all kinds of heart disease either spontaneously or by treatment medically or surgically during the past twenty-five years. Objective evidence of this reversibility is now very common. The electrocardiographic change was the most striking and the earliest of the findings, but x-ray evidence is also at hand, and even more interesting, the abolition of symptoms and signs of heart failure. Sometimes the changes have been little short of miraculous.

The electrocardiographic change consists in a clearing away or decrease in major or minor degree of the so-called hypertensive pattern, which consists of a lowering or inversion of the T waves of lead I and of the precordial leads over the region of the left ventricle, especially in the position of lead C_5. As a matter of fact C_5 is the most sensitive electrocardiographic lead of all to detect strain on the left ventricle, which so commonly results from hypertension. The lower-

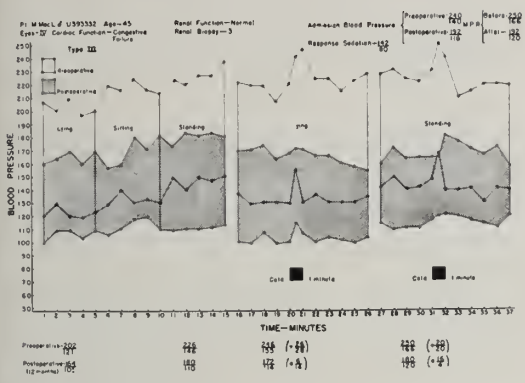


Fig. 3.—Chart of blood pressure reactions before and after operation in a successful case (H. L.)

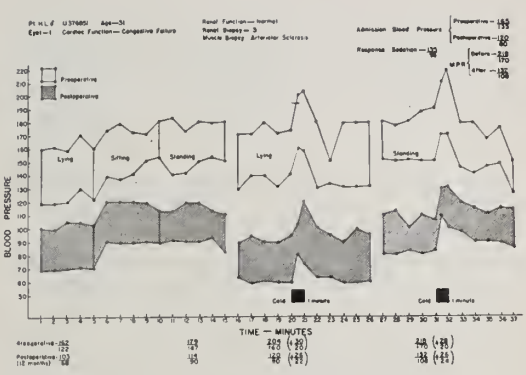


Fig. 5.—Chart of blood pressure reactions in a partially successful case (M. McL.)

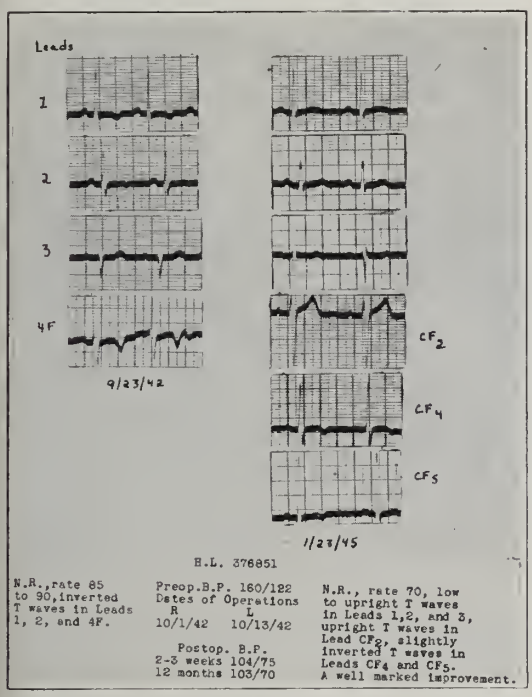


Fig. 4.—Electrocardiograms before and after operation in case of H. L.

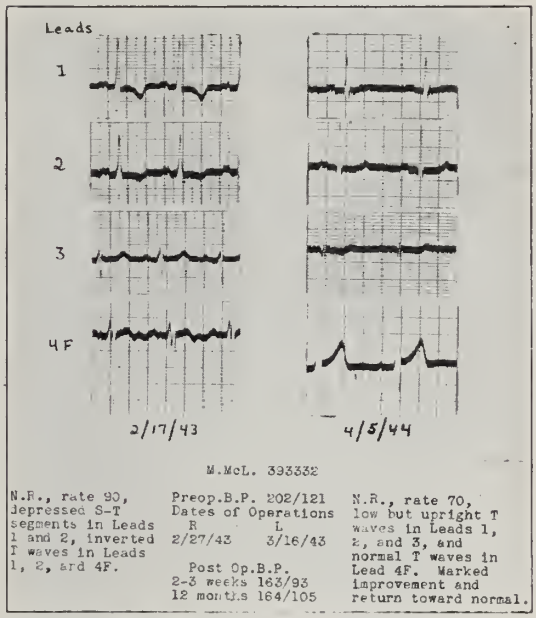
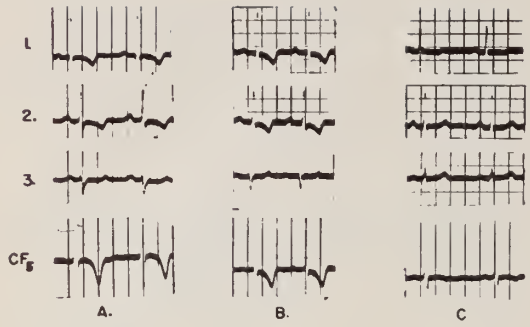


Fig. 6.—Electrocardiograms of M. McL.

ing or inversion of the T waves in lead C_5 is as a rule the very first sign of hypertensive heart disease that we possess. This fact makes it more or less obligatory for doctors to take occasional, perhaps semiannual, electrocardiograms including the chest leads in their hypertensive patients. The electrocardiographic evidence of strain on the heart from hypertension precedes, often by a considerable time interval, x-ray evidence of such strain in the form of cardiac enlargement due to dilatation and hypertrophy.

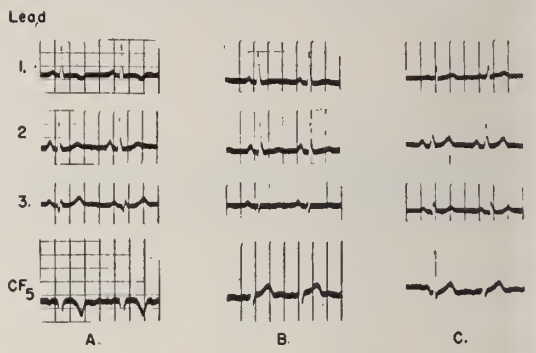
Doctor Smithwick has now carried out the operation in many hundreds of cases, approaching 1,000; he not only has a high percentage of success in reducing the blood pressure to normal or at least to reduced levels (in approximately three-fourths of the cases) but he also has achieved a very low mortality (less than 1 per cent) even though performing the operation in some patients with serious heart disease. If there is heart failure or recent myocardial infarction the operation is postponed until the congestion has been cleared or largely controlled, or until the infarct is well healed.



Reversal of the Hypertensive Electrocardiographic Pattern after Lumbodorsal Sympathectomy

E.H., a man aged 41. (A) Pre-operative ecg. taken 5-26-44 Blood pressure 194/127. Sympathectomy, Rt. {5-27-44}, Lt. {6-5-44}. (B) Ecg. taken 15 days after completion of the sympathectomy. Blood pressure 134/98. (C) Ecg. taken 1 year after sympathectomy. Blood pressure 131/87. In this case the electrocardiogram has improved markedly but is still abnormal (See Figure 1).

Fig. 7.—Rapid improvement in electrocardiogram after sympathectomy.



Reversal of the Hypertensive Electrocardiographic Pattern after Lumbodorsal Sympathectomy

H.D., a man aged 39. (A) Pre-operative ecg. taken 5-25-44. Blood pressure 189/121. Sympathectomy, Rt. {5-31-44}, Lt. {6-9-44}. (B) Ecg. taken 12 days after sympathectomy. Blood pressure 112/78. (C) Ecg. taken one year after sympathectomy. Blood pressure 101/64. In this series the amplitude of R_1 has decreased markedly post-operatively and the T waves which were inverted in Leads 1 and CF_5 have become upright.

Fig. 9.—Slow improvement in electrocardiogram after sympathectomy.

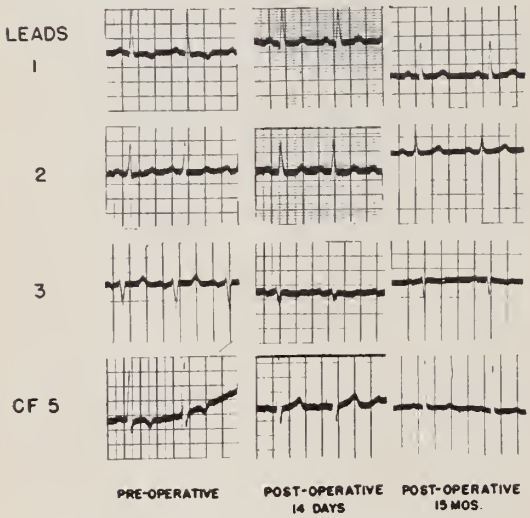


Fig. 8.—Gradual improvement in electrocardiogram after sympathectomy.

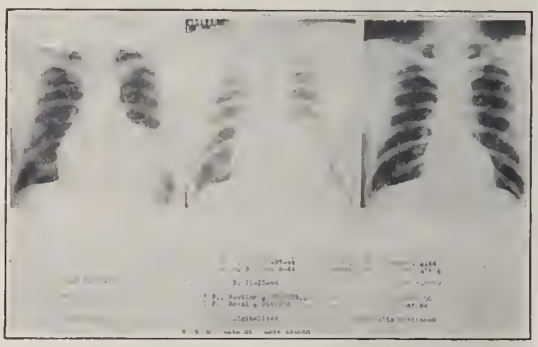


Fig. 10.—Marked decrease in heart size after operation shown by teleroentgenograms.

Examples of the changes in blood pressure levels, electrocardiograms, and x-ray pictures are shown in figs. 3 to 10 inclusive. The duration of the beneficial effect of this procedure extends now in some cases to over five years. Even if the blood pressure has not been reduced wholly to normal there may be great relief for the heart, so that clinically, success may come even though in some cases the blood pressure is not at normal levels.

Finally, the type of patient most suitable for the operative procedure is the young or middle-aged hypertensive patient, man or woman, aged 30 to 45 or 50, with relatively high diastolic pressure (120 to 140,) relatively low pulse pressure (for example, 50 to 70 mm.,) reacting well in blood pressure levels to change in posture, to cold (one hand in ice water for a minute), and to sedation (sodium amytal 3 grains hourly for three doses, the blood pressure being measured hourly through the night thereafter,) and with good renal function. The most essential factor in promoting the success of the procedure is a skilled experienced surgeon who will carry out an adequate but not hazardous degree of sympathectomy. The operation is a major one, demanding a long convalescence, but one not to be avoided when the indications for it are clear. We are hopeful

that in time it may be replaced by a "physiological" sympathectomy by drug therapy.

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Recent Advances in Immunization Procedures*

By RAYMOND P. SCHOWALTER, M. D.

Milwaukee

R. P. SCHOWALTER

A 1922 graduate of Marquette University School of Medicine, Milwaukee, Doctor Schowalter now serves as assistant clinical professor in medicine at that university. The doctor, who specializes in pediatrics, is a member of the Medical Society of Milwaukee County, the State Medical Society, and the American Academy of Pediatrics. He holds Fellowship in the American Medical Ass'n.

FEW children have a natural immunity against the common contagious diseases. Active, long term immunity can be acquired only by actually having these diseases or by being artificially immunized against them. Children are entitled to such active immunization where science has produced a satisfactory method. With this in mind, a review of the literature since 1941 and our own experience is being presented. Ever since the discovery of smallpox vaccination there has been increasing interest in the development of immunizing methods for other diseases.

Smallpox

Smallpox vaccination reactions are more pronounced than any of the others, and for that reason many postpone it until the other immunizations have been completed. Smallpox vaccinations should be given early—that is, at 5 to 9 months, and at least before 3 years of age, since postvaccinal encephalitis does not occur before that age. Revaccination should be done at 6 years of age.

Vaccination is best done on the arm. If done on the leg there is danger of diaper contamination, and in older children there is lack of sufficient rest during the reaction period. It may be done intracutaneously, but the multiple pressure method is the method of choice.[1]

Whooping Cough

Whooping cough is second among the infectious and parasitic diseases causing death in children under 5 years of age—influenza ranking first. Of the whooping cough deaths, 68.1 per cent occur under 1 year of age, while 18.8 per cent occur in the second year of life.[2] About 25 per cent of the children who contract whooping cough under 6 months of age die.[3]

* Presented before the One Hundred Fifth Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, October, 1946.

Prophylactic whooping cough vaccines used in this country prior to 1930 were unsatisfactory. In 1931 Leslie and Gardner isolated the phase I strain of Hemophilus pertussis.[4] Sauer's vaccine was made available shortly thereafter. Through the use of this, and similar phase I vaccines, whooping cough can now be prevented with the same degree of certainty as smallpox and diphtheria.

In so far as 68.1 per cent whooping cough deaths occur in the first year of life, immunization against it is started at 6 months of age. We use a vaccine that has 20 thousand million killed pertussis organisms per cubic centimeter. Three injections are given. One cubic centimeter is injected subcutaneously, low in the deltoid area with a 23 to 25 gauge ⅝ inch needle. In using a fine gauge needle there is less seepage back through the needle tract. We do not massage the site, but apply gentle pressure if necessary to prevent oozing. One week after the first injection, 1½ cc. is given in the right arm. The third dose of 2 cc. is given in another week in the left triceps region. One-half grain doses of aspirin powder are prescribed for 6 month old infants, to be given with a little milk in a spoon soon after the injection, and repeated at four hour intervals if necessary. Usually two such doses take care of the fever and discomfort that is noticed in about half the children during the following twenty-four hour period. It is not advisable to increase the formula strengths during this period. And, as the infant is just a trifle below par during the course of these injections, they should not be given on very hot days or when he has even a slight fever.

As it takes two to three months to develop a protective immunity, we have crowded these whooping cough injections at weekly intervals as soon as the child reaches 6 months of age.

Clinically we find that protection lasts at least two or three years. After that time children sometimes develop a protracted cough that is quite suspicious, although there is no whoop or positive culture. A booster dose of 20 or 30 thousand million whooping cough bacilli can be given on exposure or one year after the initial course if desired.

Phase I whooping cough vaccines are available in strengths of 10, 15, 20, and 40 thousand million bacilli per cubic centimeter and can be given according to recommendations that accompany the vaccines of reliable biologic and drug companies.

The degree of whooping cough immunity in children has been determined by complement fixation and agglutination methods, and it now seems that immunity to whooping cough may also be measured by the Flosdorf skin test. This is read in the opposite order from the Schick test. The latter, when positive, denotes a nonimmune person for diphtheria. When the Flosdorf skin test is positive it indicates pertussis immunity.[5]

Human hyperimmune pertussis serum can be obtained from Milwaukee's Columbia Hospital Serum Center and similar serum centers in this country, to give temporary passive immunity to exposed infants that have not yet been actively immunized. Usually three doses of 20 cc. are given intramuscularly at forty-eight hour intervals shortly after exposure. Some centers have these sera in the dried state.

The successful use of a globulin fraction of hyperimmune pertussis human serum has recently been reported. Treatment of active cases consists of one to five doses of 2.5 cc. given every other day.[6] Felton says: "There is an advantage in using human serum if possible, rather than animal serum, to avoid sensitivity. Human hyperimmune pertussis serum has not been observed to cause any severe local or general reaction."[3]

Diphtheria-Tetanus

Two to four weeks are allowed to elapse after whooping cough injections before we give the combined diphtheria-tentanus alum-precipitated toxoid. Two doses of 1 cc. each are given. There is seldom a reaction from this combination, though there is considerable pain for one or two minutes following the injection. They are given three months apart. A nodule persists for several weeks and one must avoid such areas when giving other injections. Combined toxoids give as high a titer, or higher, than when either toxoid is used alone. It has been shown that

one injection of diphtheria toxoid, alum-precipitated, as formerly used, does not give adequate protection. Where the two doses of combined diphtheria-tetanus toxoid have been given three months apart a satisfactory immunity response follows in two or three months. Ninety-eight per cent have developed a negative Schick test by this time.[7] A Schick test may be done prior to the child's entering school, or a booster dose of alum-precipitated toxoid may be given instead. To minimize reactions, the combination diphtheria-tetanus toxoid is not recommended for a booster dose. The reaction to a single antigen booster dose is minimal if given before 6 years of age. After a booster does of ½ cc., we are assured of a maximum amount of diphtheria protection.[8]

Three months after the second tetanus (or diphtheria-tetanus) toxoid injection, the patient is not immune to tetanus, but is eligible to receive a booster dose if an injury is such as to make this necessary. For a tetanus booster dose, especially in older children, it is advisable to use the alum-precipitated toxoid alone, so that the allergic reactions are kept down to a minimum.[9] It is advisable to read the directions that accompany the biologic product package, as some have a 1.0 cc. dose, while others require only ½ cc.

If three months have not elapsed between the second dose of tetanus toxoid and the time of injury, 1,500 units or more of tetanus antitoxin are given instead. We use a globulin concentrate antitoxin and give this only after the preliminary skin test and history of horse serum sensitiveness are both negative. Cases of sensitization to tetanus toxoid can occur, but are rare.

In the European Theatre of World War II there was only one tetanus death among United States troops, but there were many casualties among the Germans, who failed to use these preventive methods.[10]

Triple Vaccine

Recently we have tried out the triple vaccines which combine diphtheria, pertussis, and tetanus antigens. This D-P-T preparation is available in alum-precipitated and plain fluid mixtures. Three subcutaneous injections of triple vaccine are given at intervals of three or four weeks, starting at 6 months of age. D-P-T plain antigen causes less pain than the alum-precipitated mixture. To help avoid sterile abscesses a dry needle should be used for injection, rather than the same needle that was used to withdraw the vaccine from the vial. The injection site should not be massaged. When there is considerable whooping cough in the vicinity, we find the triple vaccines too slow, and the three weekly injections of plain whooping cough antigen are resorted to as previously outlined.

Chickenpox and Mumps

There is no natural immunity to chickenpox and we have no method of producing a lasting immunity except by having the disease. Inasmuch as it is usually mild if had in childhood and severe if had in adult life, we prefer to see it in infancy or early childhood. To ameliorate the attack in an exposed child whose resistance is low, we can give 30 cc. of pooled human serum soon after exposure. This may reduce the virulence of the infection.

There is no known method of producing a lasting immunity against mumps except by having the disease, and children under adolescence rarely develop complications. Convalescent serum may be of some value in preventing, or minimizing the severity of the attack, if given soon after exposure.[11]

Measles

We develop no long term immunity against measles except through an attack of the disease. Measles should be considered a serious illness, and more so for adults. If convalescent measle serum or gamma immune globulin is given directly after exposure, the disease can be prevented. It might be preferred to give the serum a little later and in smaller dosage, allowing the patient to develop a mild case that will give him a lasting immunity. The immune globulin available commercially for a number of years as a placental by-product often caused febrile reactions.

Recently the Red Cross made large quantities of gamma globulin available through the state and city health departments without cost for the material. We found no reactions with gamma globulin. To prevent measles a dose of .08 to 0.1 cc. per pound body weight is given intramuscularly as soon after exposure as possible; it is fairly effective for the first seven days. For modification, one-fourth the prevention dose is given on or about the fifth day after exposure. It is injected intramuscularly. A single dose protects a child for about three weeks.[12]

Scarlet Fever

Active scarlet fever immunization has never achieved great popularity.[13] It has not been practicable up to the present time, except in children's institutions.[1]

Where a child has not been immunized, but is Dick-positive and has been exposed to scarlet fever, he should be given temporary immunization with scarlet fever convalescent serum. Often it is practical to assume that the contact is susceptible and to give the serum without a Dick test. Where, however, there are many children cared for in a group, the Dick test should be done and all positive reactors immunized with convalescent serum. This passive immunization lasts about two weeks and should be repeated if the child remains a contact. Penicillin may be tried where convalescent serum is not available. Schuster[14] gave it to 56 scarlet fever contacts in the ships and receiving area of the Seattle–Bremerton, Washington, area. These contacts had positive cultures for beta hemolytic streptococci. They were given 20,000 units of penicillin every three hours for seven doses, or a single dose of 200,000 units in beeswax and oil. Throat cultures, in all but one case, became negative after penicillin treatment and none of the 56 developed scarlet fever.

Instead of convalescent serum or penicillin, commercial scarlet fever antitoxin also can be used, but after seeing a few severe reactions, despite negative tests for serum sensitization, one hesitates to recommend it.

Recently the Council on Pharmacy and Chemistry of the American Medical Association[15] accepted for active scarlet fever immunization a product which is given intracutaneously in three or four doses. This refined tannic acid precipitated toxin was devised by M. V. Veldee of the U. S. P. H. S. He says, "The dosage, the injection method and the time interval which seems both practicable and effective for children of grammar school age, is three graduated injections (750; 3,000; and 10,000 S. T. D.) spaced at two week intervals and injected in 1/10 cc. doses intradermally, preferably on the outer surface of the upper arm."[16]

Many cases of scarlet fever occur under 5 years of age. Tannic acid precipitate scarlet fever toxin is as slowly absorbed as alum-precipitated toxin, and a prolonged antigenic stimulus allows a reduction in the amount of toxin required. The smaller dosage reduces the incidence and severity of systemic reactions. Furthermore, a reduced number of injections increases the patient's acceptance of scarlet fever immunizations.

Summary and Conclusions

1. Active immunization against whooping cough, diphtheria, and tetanus should be started at 6 months of age. Triple vaccines now used for this purpose are well tolerated.

2. Human hyperimmune pertussis serum gives temporary protection to infants who have been exposed to whooping cough and have not yet had their routine immunization. If infants under 6 months of age contract the disease, the use of this serum may be a life-saving measure.

3. Gamma globulin (human) is a safe and effective means of preventing or modifying an attack of measles. Large quantities of this product were made available to the civilian population by the Red Cross without charge.

4. A new and milder product for scarlet fever immunization is tannic acid precipitate scarlet fever toxin. It has been accepted and approved by the American Medical Association's Council on Pharmacy and Chemistry.

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Hemoglobinuric Nephrosis*

By D. MURRAY ANGEVINE, M. D.

Madison

D. M. ANGEVINE

Doctor Angevine is professor of pathology and chairman of the department at the University of Wisconsin Medical School. A 1929 graduate of McGill Medical School, Montreal, the doctor served as an instructor in medicine and was assistant professor of pathology at Cornell University Medical School, chief of pathology and bacteriology, A. I. du Pont Institute, and pathologist for the 1st Medical General Laboratory, European Theater of Operations.

THE term "hemoglobinuric nephrosis" has recently been applied to a condition in the kidney which, although not new, was seen with increasing frequency during World War II.

The lesion is found in patients who died from various causes, most important of which are severe injuries, especially of the crushing type, burns, blood transfusions, and sulfonamide intoxication. Such cases run rather a characteristic clinical course, gradually develop an elevation of nonprotein nitrogen and die with oliguria or anuria. The kidney is enlarged, there are varying degrees of pallor, and frequently intense red streaks along the medullary striations. Microscopically, the conspicuous features are degeneration of the distal convoluted tubules and a deposition of red-brown granular material.

Early in the development of our knowledge of this condition it was thought that all the pigment in the kidney tubules was hemoglobin derived either from blood or muscle in the form of myohemoglobin, thus the term hemoglobinuric nephrosis. It is now known that substances other than hemoglobin may be present, and because the lesion always involves the same segment of the uriniferous tubule (namely the distal convoluted portion or the collecting tubule) it is felt by some that the term "lower nephron nephrosis" is more appropriate. However, since in the majority of instances some hemoglobin compound is the important factor, the term "hemoglobinuric nephrosis" seems satisfactory.

* Presented before the One Hundred Fifth Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, October, 1946.

It is hard to explain why the significance of this lesion remained so long unrecognized. Most civilian pathologists have seen and described it, especially in death due to transfusion. It is possible that as traumatic cases are not diagnostic problems, they have received less attention and the lesions have been overlooked.

Attention was first focused on the subject in this country by the work and writings of British pathologists[1, 2, 3, 4] who described a distinctive lesion of the kidney in patients who died following severe injuries associated with crushing of muscles. The original disease was described as the "crush syndrome" and the classic picture occurred in patients buried under large volumes of rubble during the London blitz.

Probably the first reference to injuries of this nature was in 1910 in individuals buried during the Messina earthquake.

The Germans recognized a similar type of injury during World War I. Frankenthal,[5] in 1916, described muscle necrosis in soldiers buried by mine explosions, and the anatomic changes in the kidney were first described in 1917. The first reference to this condition in traffic accidents was made by Husfeldt and Bjering[6] in Oslo in 1937.

World War II has afforded a most unusual opportunity for an extended study of this disease. Complete protocols and slides on all autopsies in the United States Army are forwarded to the Army Institute of Pathology in Washington, where the initial findings are carefully checked by competent pathologists. Lucke[7] has collected all of the fatal cases in the U. S. Army with this lesion, 538 with complete records.

Mallory[8] observed the condition in 10 per cent of the first 1,000 autopsies he reviewed in the Mediterranean Theater. Among 427 battle casualties dying in hospitals, the incidence was 18.6 per cent. In the European Theater of Operations, Harman and I found the renal lesions in 5 per cent of 3,223 routine autopsies, whereas in 1,065 cases dying as the result of enemy action, the incidence of hemoglobinuric nephrosis was 15.2 per cent. This indicates a significantly higher incidence in the battle casualty group.

As experience with this disease increases, it becomes more and more evident that multiple factors are concerned with its production and must be considered in any discussion of etiology. It might be well to state that this lesion is not peculiar to the armed forces; it has been observed in a considerable number of autopsies performed at Wisconsin General Hospital, Madison, during the past year.

As cases accumulated they fell logically into the following groups:

- Battle wounds
- Crushing injuries
- Burns
- Blood transfusion reactions
- Hemorrhage
- Abdominal operations
- Sulfonamide intoxications
- Heat stroke
- Gas gangrene
- Trench foot
- Blackwater fever
- Variety of poisons
- Hemolytic anemia
- Uteroplacental damage

It is evident from such a list that several overlapping factors may be present in any case so that the determination of an exact cause was difficult and often impossible.

The extent of involvement of the kidney varied considerably. In our study, only cases with evidence of azotemia, oliguria, casts, and a considerable degree of kidney involvement are included.

As one might expect, battle wounds comprised the largest group. Since most of the cases occurred in men with extensive wounds, the factors of hemorrhage and destruction of muscle tissue were both usually present. It was virtually impossible to determine whether a lesion was attributable to release of myoglobin from traumatized muscle or from hemoglobin associated with hemorrhage.

About one-fourth of 80 cases analyzed by us occurred in patients with extensive vascular damage, usually severance of the femoral artery. This suggested that myoglobin may have been released from muscle deprived of its normal vascular supply; however, the factor of hemorrhage could not be excluded.

We did not have adequate equipment, time, or opportunity to determine the concise nature of the pigment in the urine or the kid-

neys. Bywaters has made such chemical studies and will report them.

Since the severely wounded were frequently in shock and hemoglobinuric nephrosis was observed when no other significant factor was present, it is logical to assume that shock is of great importance; its evaluation in this connection, however, is difficult. To complicate the situation further, nearly all cases were given blood transfusions or sulfonamide therapy and frequently both. It is known that either one alone may produce the condition and frequently did.

Blood transfusion accounted for the lesion in approximately 8 per cent of the cases we studied. These patients had a history of reaction to transfusion or evidence of intravascular hemolysis with precipitation of hemoglobin casts in the distal part of the tubule. Incrimination of the sulfonamides depended upon clinical evidence or upon the presence of drug in the kidney tubules.

The kidney lesions in burn cases are best explained on the basis of intravascular hemolysis and/or destruction of muscle. Similar possibilities exist in cases of gas gangrene.

Clinical and Laboratory Manifestations

The most important condition is a rapidly progressive renal insufficiency frequently complicated by shock and vomiting.

There is a diminution in urinary output to less than 500 cc. daily and frequently anuria. The urine is often dark in color, either bloody or smoky. Specific gravity is low and usually fixed around 1010. The reaction is strongly acid.

Urinary sediment contains granular and pigmented casts, red blood cells or spherules derived from hemoglobin that resemble red blood cells.

These heme compounds can be demonstrated for three to four days and finally disappear.

Proteinuria appears early and persists.

Careful microscopic examination of freshly obtained urine is neglected all too often.

There is a rapid rise in nonprotein nitrogen. All cases have an increase in potassium and phosphates. There is a decrease in the alkaline reserve and a lowering of the blood chlorides.

There is a low initial blood pressure which gradually becomes elevated above normal as the disease progresses. The presence of edema is variable; if present, it is slight or moderate and is usually of the lower extremities.

The patients die in uremia.

The mortality rate is very high, probably 90 per cent.

In our experience the average interval from the time of wounding to death was ten and five-tenths days.

Pathologic Anatomy

Grossly the kidneys are swollen and the weight increased. In about 10 per cent of cases the combined weight is between 400 and 600 Gm. in contrast to a normal average of 300.

The cortex is usually pale and the striations in the medulla accentuated and mahogany in color.

Casts can be readily demonstrated at the autopsy table by cutting a thin section of tissue with a razor blade and examining it directly with a microscope.

Histologic examination reveals: (1) degeneration and necrosis of the thick loop of Henle and the distal convoluted tubules; (2) heme casts in the lumina of the tubules; (3) edema and inflammation of intertubular tissue; and (4) thrombosis of adjacent veins.

One theory of the pathogenesis of this condition is that hemoglobin is precipitated in the lower segment of the nephron, probably as hematin, when the intratubular fluid becomes sufficiently acid. In this same connection it has been demonstrated[9] that intravenous injections of myoglobin may lead to renal failure with pigment retention when the urine is in a pH range of 4.5 to 6.1. Because of this view that acidity is important, alkalinization has been widely used as a therapeutic measure in cases with intravascular hemolysis or severe muscle trauma.

Some hold to the supposition that cells of the kidney tubules are damaged by ischemia, by some toxic chemical substance from damaged tissue, or because of acid urine. The heme casts are then precipitated in the damaged tubules.

Lowered filtration pressure also has been suggested as a factor that may lead to accumulation of pigment within the tubules.

A precipitating factor in the production of lower nephron disease is that of physicochemical alteration of the blood. Such alterations are chiefly the result of destruction of tissue, excessive vomiting, and dehydration.

Finally it has been shown that blood flow in the kidney may vary independently of the general circulation. In shock the total circulating volume of blood decreases one-half the normal value, whereas the flow through the kidney decreases to one-tenth or one-twentieth or even less. This in turn causes oliguria or anuria.

Further clinical and experimental observations are required for a clearer understanding of the mechanism of this condition. Such studies offer attractive avenues of approach to certain unknown functions of the kidney tubule.

In conclusion I wish to re-emphasize that a new disease has not been described, but I have merely attempted to call your attention to a condition seen in a wide variety of circumstances, that is frequently unsuspected, therefore untreated, and heretofore usually unrecognized in routine postmortem examinations.

Note—Col. Balduin Lucke, M. C., A. U. S., kindly placed his material at my disposal. A complete report of his work was scheduled to be published in the November 1946 number of *The Military Surgeon.*

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UROLOGY AWARD

The American Urological Association offers an annual award "not to exceed $500" for an essay (or essays) on the result of some clinical or laboratory research in urology. Competition shall be limited to urologists who have been in such specific practice for not more than five years and to residents in urology in recognized hospitals.

For full particulars write to Thomas D. Moore, M. D., Secretary, 899 Madison Avenue, Memphis, Tennessee. Essays must be in his hands before May 1, 1947.

The selected essay (or essays) will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Hotel Statler, Buffalo, New York, June 30–July 3, 1947.

NATIONAL GASTROENTEROLOGICAL ASSOCIATION

1947 Award Contest

The National Gastroenterological Association announces its Annual Cash Prize Award Contest for 1947. One hundred dollars and a Certificate of Merit will be given for the best unpublished contribution on gastroenterology or allied subjects. Certificates will also be awarded those physicians whose contributions are deemed worthy.

Contestants residing in the United States must be members of the American Medical Association. Those residing in foreign countries must be members of a similar organization in their own country. The winning contribution will be selected by a board of impartial judges and the award is to be made at the Annual Convention Banquet of the National Gastroenterological Association in June of 1947.

Certificates awarded to other physicians will be mailed to them. The decision of the judges will be final. The Association reserves the exclusive right of publishing the winning contribution, and those receiving certificates of merit, in its Official Publication, THE REVIEW OF GASTROENTEROLOGY. All entries for the 1947 prize should be limited to 5,000 words, be typewritten in English, prepared in manuscript form, submitted in five copies, accompanied by an entry letter, and must be received not later than April 1, 1947. Entries should be addressed to the National Gastroenterological Association, 1819 Broadway, New York 23, New York.

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Benadryl and Pyribenzamine

Numerous investigations have led to the current belief that allergic reactions are related to the actions of histamine, or some closely allied substance, as liberated or formed from precursors by enzymatic activity. Therefore, studies were directed toward this substance with the hope of finding a chemical which would combine with it, interfere with its formation, or otherwise prevent its action.

Two promising drugs, presently available for antihistaminic action, are benadryl and pyribenzamine, the former being somewhat more extensively employed than the latter, is better documented at this writing. In general these two drugs are very much alike in action in that either, when given prophylactically or as treatment to laboratory animals, prevented or markedly reduced anaphylactic shock or the direct action of histamine appropriately administered. These studies were followed by toxicologic investigations in the laboratory. It was found that both drugs possessed roughly the same order of toxicity, though benadryl appeared to be somewhat less toxic than pyribenzamine in several species of laboratory animals. In the instance of benadryl, all animals receiving fatal doses died as a consequence of generalized convulsions, whereas pyribenzamine produced an occasional convulsion but death occurred as a result of profound depression.

Clinically, these new drugs have been found useful in pollen sensitivity, angioneurotic edema, urticaria following penicillin or other medication, irradiation sickness, idiopathic erythema multiforme, migraine, dysmenorrhea, reactions to thiamine, insect bites, Ménière's disease, and smooth muscle spasm or tenseness in allergic patients.

Either drug is to be administered orally in the control of symptoms of histamine sensitivity according to individual requirements, intervals of drug taking being determined by a return of the symptoms. It should be noted that these drugs are symptomatic in action and are not basically curative since cessation of drug action is usually followed by reappearance of symptoms, providing the exciting cause continues to exist.

In subjects receiving benadryl there have been described symptoms of drowsiness and loss of judgment, dizziness, nervousness, numbness in the extremities, nausea, and the milder atropine-like effects. Following pyribenzamine administration, side-effects such as nausea, grogginess, and drowsiness have been observed. The incidence of these undesired side-actions appears to be, on the whole, slightly greater after benadryl, with something over 30 per cent, than after pyribenzamine (roughly 15 per cent.) These figures are not well-established but may serve at present as a probable estimate.

In instances of disturbing side-actions and of gross overdosage, for example by accident, the writer would recommend symptomatic treatment. For grogginess, ephedrine or benzedrine has been employed. However, it would be prudent at this time to remember that in laboratory animals death is produced by benadryl through convulsions, whereas after pyribenzamine, death ensues following a period of profound depression. Consequently, treatment of poisoning by either should be cautious and symptomatic.

Up to the present time neither increased tolerance nor increased sensitivity appears to have been reported, though, as in the case of many drugs, individual natural susceptibility does occur, as proved by the frequent appearance of undesirable side-actions and also the differences in dosages required by different individuals.—A. L. TATUM.

Notes on Clinical Pathology

Editors—WALTER H. JAESCHKE, M. D., University of Wisconsin, Madison, and
S. B. PESSIN, M. D., Marquette University, Milwaukee

Pregnancy Tests

The pregnancy test is a well-established, widely employed laboratory procedure. It is unfortunate that this specific laboratory test is not used as often as conditions indicate. Consequently every hospital has in its records cases of unintentional interrupted pregnancies. Perhaps it would be advisable for hospitals to establish a rule that no uterine curettage or hysterectomy be performed in a woman of child-bearing age who has missed a menstrual period unless it is proved that the pregnancy test is negative.

The pregnancy test is positive five to fourteen days after conception. The pregnancy urine factor (P. U.) or anterior pituitary-like hormone (A. P. L.) also designated as the choriogonadotropic hormone, is not only present in pregnancy but is also produced in hydatiform moles, chorio-epitheliomas, and certain malignant neoplasms of the testicle.

The most common pregnancy tests are:

1. Aschheim–Zondek: performed in immature female mice and requires four to five days to complete the test.
2. Friedman: performed in rabbits more than 16 weeks of age. Test is complete in forty-eight hours.
3. Salmon, Geist, Salmon: 20 to 40 day old mice; test positive between five to twenty-four hours.
4. Frog (South African) test: test positive in four to twelve hours.

Space allotted in this page does not permit elucidating on the advantages and disadvantages of the methods enumerated. Any of the above tests yield 98 to 99 per cent accurate results when performed by the experienced.

Indications for pregnancy tests:

1. Suspected intra-uterine or ectopic pregnancy.
2. Missed or incomplete abortion.
3. When uterus is larger than the corresponding month of pregnancy indicates.
4. When a gravid uterus is not increasing in size.
5. Uterine bleeding in women of child-bearing age who have missed a menstrual period.
6. Hysterectomy for large fibroid uterus in women of child-bearing age who have missed one or more menstrual periods or who experience abnormal bleeding.
7. Pelvic pain in women who have missed one or more menstrual periods.
8. Suspected hydatid mole (dilution test.)
9. Suspected chorio-epethelioma (dilution test.)
10. Tumor of a testicle.
11. Repeated pregnancy tests are indicated following removal of hydatid mole, chorio-epithelioma, and testicular tumors as a guide for further therapy (metastasis of chorio-epithelioma and malignant neoplasms of the testicle yield positive pregnancy tests even if primary tumors have been completely removed.)

Negative pregnancy may indicate:

1. Absence of pregnancy and other conditions that may yield positive reaction (hydatid mole, chorio-epithelioma, malignant testicular neoplasms.)
2. Missed abortion with complete necrosis of placental tissue.
3. Complete degeneration of chorionic villi in ectopic pregnancy.
4. Complete separation or removal of a hydatid mole (advisable to repeat if one test is negative.)
5. Probably no metastasis in patient having had a chorio-epithelioma or malignant neoplasm of testicle removed. (Minimal metastasis may yield negative tests—therefore it is advisable to repeat periodically.)
6. Performing of pregnancy test too soon.
7. Improper collection of urine.

Further discussion of pregnancy tests will appear next month.—S. B. PESSIN, M. D., *Marquette University.*

As It Looks to Your State Board of Health

(These timely discussions of health problems are prepared by staff members as a special service to Wisconsin's physicians.)

The Physician and Nutrition

Should the practicing physician be concerned about nutrition or is this wave of popular appeal to the public just another example of what happens when wishful thinking is based on pseudoscientific data?

The exploitation of uncertainties as to what constitutes a normal need for the essential vitamins has been confusing to the physician. The lack of agreement of what constitutes normal nutrition and of the point at which a state of mild nutritional deficiency begins has also been a serious handicap up until now. The physician's basic scientific training leads him to question the assertion that if the patient eats certain basic foods he will build up his resistance, will avoid many illnesses, and enjoy positive health.

However, if, by placing his obstetric patient on a definite diet designed for her special needs, he would be able to avoid eclampsia altogether, and at the same time reduce chances of having a premature baby to one-twelfth of the present expectancy, the attending physician would undoubtedly be interested in revising his concept of the indefiniteness of the results of good nutrition. Now is the time to do that re-evaluating.

In a group of 2,000 mothers carried through pregnancy on a supervised diet, there resulted but 6 premature births, as compared to 81 occurring in a control group of 2,000 others who had been carried along at the same time and in every respect in the same manner except that they had no guidance as to nutrition. Furthermore, none of these 6 prematures died. This is very significant in view of the fact that prematurity is the largest single cause of infant deaths. Eclampsia and preeclampsia were entirely absent among the 2,000 mothers whose diets were supervised, and mild toxemias were reduced 75 per cent as compared with the controls.

This piece of clinical research was carried on in a Philadelphia hospital over a five year period, interrupted by the war, as reported at a recent nutrition conference by Dr. Winslow T. Tompkins of Philadelphia. When this study was started, there was no specific diet for normal pregnancy in the literature. Specific dietary directions are a necessity for success. Six small meals daily were found most effective and restriction of fruit juices to twice daily was found to reduce edema. The positive approach of setting up a good diet was used in this study, as contrasted with a negative one of restricting foods by order. Patients were told what to do, not left in confusion with only directions of what to avoid doing. From this study of 4,000 obstetric patients, there is much evidence that toxemias are nutritional deficiencies.

The results of applying principles of good nutrition to the civilian population of England during the war are now accepted as evidence of their effectiveness. The Army, Navy and the Air Force are convinced of the effectiveness of good nutrition on the stamina, the resistance to infection, and the general over-all efficiency of our fighting men.

The knowledge of nutrition is increasing rapidly. Only our very recent graduates have had these later developments available as part of their formal training. The rest of us need to stay abreast of recent advances by taking postgraduate training in one form or another so that our patients may have the benefit of what is now no longer just an indefinite concept.

The answer to our original question is that the physician should be, and is, very much interested in nutrition, and now is the time to do something about it.—Carl N. Neupert, M. D., *State Health Officer.*

. . . . THE PRESIDENT'S PAGE . . . .

Awakening of Our Sense of Duty

THE most casual analysis of the results of the last election reveals how wide is the swing of the pendulum of public opinion. The time is here when medicine should give thought to and openly take part in the science of government—call it politics if you will. No group of men should be more interested in the government of this country. No group is more qualified to distinguish between the charlatan and the sincere politician. If we state that we fear soiling our fingers by mixing in politics we are virtually saying to the ward-healers and corruptionists, "You run it." We should make it our business to assure ourselves that the men we choose to enact our laws and those we select to enforce them are clean, able, and honest; that they believe in America and in those principles of government which we call American.

The prestige of the doctor as an individual and of medicine as a group is indeed great. What are we going to do with that prestige? Are we going to use it to help retain in this country the fundamental principles which made this the greatest nation the world has ever known? Are we going to use that prestige for selfish purposes? Are we going to fail to carry the load of responsibility to society that this prestige has placed upon our shoulders? For surely prestige ever carries with it a like responsibility.

It is my firm conviction that we as a group will accept our responsibility. Today ideologists are striking at the very roots of free enterprise. Socialization of medicine happens to be their immediate goal. It is but an incident in their program. It must be defeated, not for selfish reasons, but because it is a threat to our way of life. While the ideologists may have lost one battle in the recent election we may be sure that they do not consider they have lost the war. They will be back with more ammunition and with more strategies for the next battle. Complacency on our part at this time may spell ultimate disaster.

The welfare of society and the welfare of medicine go hand in hand. They cannot be divorced. Society depends upon medicine and medicine upon society. If we sublimate our own interests in our fight for the interest of society we need not worry about the effect on medicine.

The strength of medicine is not in the few who hold the higher offices, or in members of committees. Neither is the strength of medicine in the teachers and the scientific researchers. The strength of medicine is in the *membership of the county societies,* those men scattered throughout the state in the metropolitan areas and the rural districts. The prestige of medicine is built upon the lives of these men, and upon these men we must build our hopes of the survival of our present form of medical practice and free enterprise. It is upon the level of the county societies that the battle must be fought and won.

We need an awakening of our sense of duty to our country along this line, and it will be one of the objectives of this administration of your Society to do everything within its power to aid in such an awakening.

C. A. Dawson

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« « « EDITORIAL » » »

340,000 Contact Points

MEMBERS of the State Medical Society are well aware that the Wisconsin Veterans Medical Service Agency has been established. The majority have already signified their participation in this important service—important to the medical profession as an opportunity to demonstrate to more than 340,000 Wisconsin veterans that organized medicine has the ability and the will to give them the service they deserve without the agonies of red tape which characterized medical care in so many instances after World War I.

The response of Wisconsin physicians as to participation in this program is gratifying. But merely signifying a willingness to handle veteran cases is not sufficient. To be effective the program must have the thorough understanding of every physician who has agreed to share the responsibility of this service to the many young men and women who will qualify for assistance.

Recognizing the importance of this program to the profession and the veteran alike, the January issue of *The Journal* (the Blue Book Issue) will carry a special feature on the Wisconsin Veterans Medical Service Agency which should be studied with care.

Medicine has emerged from the war with the strong support of those men who had occasion to receive medical care while in service. This good will can be trebled or destroyed by the manner in which the medical services are rendered to them as civilians qualifying for care under terms of the veterans program. It offers an opportunity in professional and public relations which can mean much to medicine in the years ahead.

We recommend the special section of your January *Journal* as "required reading." It will be both informative and interesting, we promise.

Minutes of the Council, Madison, May 26, 1946

1. Call to Order

The Council was called to order by Chairman Gavin at 10:00 a. m., Sunday, May 26, 1946, at the Heidelberg Hofbrau, Madison.

2. Roll Call

Councilors present were Doctors Pechous, Vingom, Spiegelberg, Heidner, Gavin, Beebe, Nadeau, Christofferson, Arveson, Witte, Fitzgerald, Blumenthal, Leahy, and Past-President Fidler.

Also present were President Minahan, President-Elect Dawson, Speaker Cary, Doctor Gundersen, president of the State Board of Health; Doctor Neupert, state health officer; Doctors Sargent and Stovall, delegates to the American Medical Association; Doctor Supernaw, member of the Council on Medical Service and Public Relations; Dr. H. Kent Tenney, chairman of the child health survey of the American Academy of Pediatrics in Wisconsin; Messrs. Francis Lamb and Robert B. L. Murphy, legal counsel for the Society; Secretary Crownhart; and Assistant Secretary Ragatz.

3. Approval of Minutes of January Meeting

Upon motion of Councilors Blumenthal–Fitzgerald, the minutes of the January, 1946, meeting were approved, and the motion was carried unanimously.

4. Waiver of 1945 Dues—Dr. G. A. Kriz, Elm Grove, Wisconsin

Doctor Kriz, who was formerly located in Milwaukee County, moved to Waukesha County in 1944. He was elected to membership in the Waukesha County Medical Society in 1945 but was not advised of that fact nor billed for his dues that year. Consequently, he was listed as delinquent on the State Society membership records. When he paid his dues for 1946, he did not know that he had been elected to membership in 1945. So that his membership might be maintained consecutively in the State Society records, it was suggested that the question be referred to the Council for consideration. Upon motion of Councilors Leahy–Fitzgerald, Doctor Kriz' dues for 1945 were waived. The motion was approved unanimously.

5. Honorary Membership—Dr. H. V. Bancroft, Blue Mounds, Wisconsin

Doctor Vingom, councilor from the third district, reported that the Dane County Medical Society had honored Doctor Bancroft at a special meeting in 1945. He stated that the county society felt that honorary membership should be granted Doctor Bancroft for his contributions to the practice of medicine in the state.

Upon motion of Doctors Vingom–Spiegelberg, honorary membership was granted unanimously to Doctor Bancroft.

6. Dates for 1947 Annual Meeting Set

Secretary Crownhart stated that it would be of considerable assistance to the central office if the Council could fix the dates for the 1947 meeting at this time. He explained that the State Medical Society of Wisconsin attempted to correlate its meeting with that of surrounding states and that if the dates of October 6, 7, and 8 which had been suggested, could be approved, necessary arrangements could be made, anticipating the action of the House of Delegates in the fall at which time the place of the meeting would be fixed.

Upon motion of Doctors Fitzgerald–Christofferson, the dates for the 1947 annual meeting were established as October 6, 7, and 8, and the motion was carried unanimously.

7. Appropriation Authorized for Conference of Presidents and Other Officers of State Medical Associations

Secretary Crownhart stated that a communication had been received from the Conference of Presidents and Other Officers of State Medical Associations requesting a contribution of $50 from Wisconsin for membership in the organization. Assistance (based on the amount of membership of each state society) was being asked from all state medical societies so that an annual budget of $1,300 could be obtained.

Past-President Fidler explained that in February of 1945, the Michigan State Medical Society called the presidents of various state medical societies together for a conference on questions confronting the medical profession. In April, 1945, Doctor Fidler visited the Michigan headquarters with other officers and during the business session that followed, rules and regulations were passed and committees appointed to carry on the work in various states.

Upon motion of Doctors Fidler–Heidner, unanimous approval was given to contributing $50 for membership in the Conference.

8. Committee on Military Service Created

The following letter from Dr. G. F. Lull, secretary of the A. M. A., received in the secretary's office, was referred to the Council for consideration:

"To the Secretaries of the Constituent State Medical Associations:

"The Committee on National Emergency Medical Service of the American Medical Association, which was appointed in accordance with recommendations of the Board of Trustees adopted by the House of Delegates at its meeting held in December, 1945, has requested the Board of Trustees to give them permission to suggest that each constituent state medical association appoint a similar committee. This request has been approved by the Board. The recommendation adopted by the House of Delegates is as follows:

> "The Board of Trustees would recommend to the House of Delegates that it authorize the Board of Trustees of the American Medical Association to appoint a committee of seven to be known as the Committee on Military Service. This committee shall include four civilian physicians who served in the war and three others. The committee will study the many communica-

tions that have been received and the suggestions made by physicians in the armed forces. The committee will also formulate policies for recommendations to be forwarded through the Surgeons General to the Secretary of War and the Secretary of the Navy expressing the views of the medical profession in planning for proper utilization of the services of physicians in any national emergency.

"The Chairman of the Committee, Dr. Edward L. Bortz of Philadelphia, desires that as much publicity as possible be given the formation of these committees."

Secretary Crownhart stated that the committee appointed pursuant to that recommendation had suggested that each constituent state medical association appoint a similar committee.

Dr. James C. Sargent of Milwaukee, a member of the national committee, explained that it is the intention of the national committee to seek information from medical officers of the last war, along with the information from the services, with the idea of trying to develop some sort of program based upon past experience, that might lead to the establishment of medical service in the event of another war.

Upon motion of Councilors Vingom–Spiegelberg the chairman unanimously was authorized to appoint a committee consisting of four ex-service men and three others constituting a Committee on Military Service in the state.

9. Dues of Veterans Newly Admitted to Membership

Secretary Crownhart asked the Council's advice on the following problem: Soon after the war started, the State Society enacted a special permissive by-law so that county societies could elect to war membership a physician who entered service directly upon graduation and who had not previously been a member of any state society. In 1941 the Council authorized a waiver of dues for a period of six months for members who returned from service.

Secretary Crownhart stated that under policies approved by the Council, members of the Society returning from service paid no dues for a period of six months from date of discharge. This policy prevailed even in the case of those who had been elected to service membership while in service.

He stated that many county societies reported that physicians who had not been members of any society while in service in not applying for membership, questioned whether they were not also eligible for this waiver of dues.

Upon motion of Doctors Arveson–Spiegelberg, unanimous approval was given to waiving dues for veterans newly admitted to membership.

10. Section on Internal Medicine and Cardiology Renamed Section on Internal Medicine

Assistant Secretary Ragatz stated that at the last meeting of the Council on Scientific Work Dr. Chester Kurtz, chairman of the Section on Internal Medicine and Cardiology, had expressed its wish that the name of the section be returned to the name formerly used,—the Section on Internal Medicine.

Doctor Kurtz explained that the word "cardiology" held little significance as it was a part of internal medicine.

Upon motion of Doctors Blumenthal–Fidler, unanimously carried the name of the section was changed to the Section on Internal Medicine.

11. Special Session of the House of Delegates

The following petition, signed by twenty-two delegates, seventeen from Milwaukee County, two representing sections of the Society, and three from other counties, was presented to the Council for consideration:

Pursuant to the provisions of Article VIII, Section 3, of the constitution of the State Medical Society of Wisconsin, we, the undersigned, members of the House of Delegates, do hereby petition for a special meeting of the House of Delegates of the State Medical Society of Wisconsin, and petition further that such meeting be held in the Elizabethan Room of the Milwaukee Athletic Club in the City and County of Milwaukee, at 10:00 A. M., on the 1st day of June, 1946, for the purpose of voting upon the following resolution:

> *Resolved* that the House of Delegates of the State Medical Society of Wisconsin does hereby approve the manner of establishment of the Surgical Care plan established and operated by the Medical Society of Milwaukee County, providing always that such approval places no financial obligation nor liability on the State Medical Society of Wisconsin.

We make such petition because Sec. 148.01 (3) (a) of the Wisconsin Statutes provide

> "The state society, or a county society in manner approved by the state society, shall have the power to establish in the state, or in any county or counties therein, a non-profit plan or plans * * *"

The state insurance department of Wisconsin has declared that the Surgical Care plan operated by the Medical Society of Milwaukee County does not have the approval of the State Medical Society of Wisconsin. They state that they were informed by Mr. Charles H. Crownhart, secretary of the State Medical Society of Wisconsin on or about March 14, 1946, that the State Medical Society of Wisconsin approved the Surgical Care plan only as an experiment and only providing that not over five thousand people were covered by it.

Therefore, we petition for such meeting so that the medical profession in Wisconsin may either approve the Surgical Care plan and permit it to operate, or disapprove it and cause it to cease operating.

Dated this 7th day of May, 1946.

F. E. Drew, Delegate from Milwaukee County
T. J. Aylward, Delegate from Milwaukee County
F. A. Ross, Delegate from Milwaukee County
W. A. Ryan, Delegate from Milwaukee County
Aaron Yaffe, Delegate from Milwaukee County
Mark J. Bach, Delegate from Milwaukee County
Edward D. Schwade, Delegate from Milwaukee County
M. J. Fox, Delegate from Milwaukee County
S. A. Morton, Delegate from Milwaukee County
Forrester Raine, Delegate from Milwaukee County
Robert F. Purtell, Delegate from Milwaukee County
Chester M. Echols, Delegate from Milwaukee County

John W. Truitt, Delegate from Milwaukee County
O. A. Sander, Delegate from Milwaukee County
Joseph J. Gramling, Jr., Delegate from Milwaukee County
Norbert Enzer, Delegate from Milwaukee County
Robert P. Montgomery, Delegate from Section on Orthopedics
Jerome W. Fons, Delegate from Milwaukee County
Carl J. Weber, Delegate from Sheboygan County
W. C. Stewart, Delegate from Kenosha County
T. Chas. Hemmingsen, Delegate from Racine County
J. E. Habbe, Delegate from Section on Radiology

Discussion then followed as to various problems involved in calling a special session of the House, with the opinion being offered that the petition was not self-operating as to time and place, but constituted a mandate that the House be called into session by the Council. Following lengthy discussion, and the offering of several motions, variously seconded, and several times amended, the secretary stated that his records showed the substance of the question before the Council to be the original motion of Doctor Vingom, as variously seconded, and as amended by unanimous consent, as follows:

That the Medical Society of Milwaukee County present to the state office of the State Medical Society the detailed mode of operation of the Surgical Care plan, including all basic fiscal and actuarial data; also including managerial and administrative procedures; and also including copies of all types of contracts now in effect, such as: the agency contract with Associated Hospital Service, Inc., the participating physicians' contract, and the schedule of benefits.

It was also moved that such information be transmitted by the state office to the delegates not less than seven days prior to the special session of the House.

Following further discussion, the motion was unanimously approved.

Discussion then followed as to setting the time and place of the meeting and the advisability of reviewing material to be presented to the delegates. Upon motion of Doctors Vingom–Christofferson, the Council authorized the chairman to appoint a committee of six men, three from Milwaukee County and three from the state at large, to review the material to be presented to the delegates for their consideration at the special session of the House. A roll call on this motion showed the following in favor of the motion: Doctors Pechous, Vingom, Spiegelberg, Heidner, Gavin, Nadeau, Christofferson, Witte, Fitzgerald, Blumenthal, and Leahy. The following were opposed: Doctors Arveson and Beebe. Doctors Wilkinson, Ekblad, and Fidler were absent at the time the roll was called.

Upon motion of Doctors Christofferson–Spiegelberg, the dates for the special session of the House of Delegates were set as June 22 and 23 and the place as Madison. The motion was carried unanimously.

Upon motion of Doctors Heidner–Fitzgerald, the following recommendations of the Executive Committee of the Council were approved: (1) The secretary and chairman of the Council were instructed to transmit the material on Surgical Care not for publication; (2) A committee of three councilors was authorized to approve a special news release announcing the special session; and (3) The House of Delegates transact its business in executive session.

Upon motion of Doctor Pechous, variously seconded, the secretary was authorized to notify delegates and alternate delegates by telegram the dates of the meeting. The motion was unanimously carried.

Doctor Witte then restated as an original motion a motion previously offered by him as an amendment and declared out of order. This motion was as follows: "That the Council approve the resolution incorporated in the call for the special session." The motion was seconded by Doctor Beebe. Following discussion, it was moved by Doctors Vingom–Pechous that the motion be tabled. A roll call was taken with the result that nine were in favor of tabling Doctor Witte's motion, four were opposed to tabling it, and three were absent. Those in favor of tabling were Doctors Pechous, Vingom, Spiegelberg, Heidner, Gavin, Nadeau, Christofferson, Blumenthal, and Leahy. Those opposed were Doctors Beebe, Witte, Fitzgerald, and Past-President Fidler. Those who were absent were Doctors Arveson, Ekblad, and Wilkinson.

For the purpose of issuing a formal call of the House of Delegates, the following resolution was then offered by Doctors Vingom–Heidner and unanimously carried:

Resolved that a special session of the House of Delegates of the State Medical Society of Wisconsin is called and will be held at 10:00 a. m., in the City of Madison, Wisconsin, on June 22, 1946, in the Loraine Hotel, for the purpose of considering a resolution relating to the Surgical Care plan of the Medical Society of Milwaukee County, as set out in a petition dated May 7, 1946, and signed by twenty-two members of the House of Delegates of the State Medical Society of Wisconsin, a copy of said petition being attached to this Call; and for the purpose of adopting any other resolutions or taking any other action relating to the Surgical Care plan which may be deemed appropriate at said session.

12. Approval Given to Contribution for Milwaukee Centennial

Secretary Crownhart reported that the Executive Committee of the Council had approved a contribution of $500 to the Medical Society of Milwaukee County for the Milwaukee Centennial and asked for action of the Council as a whole.

Upon motion of Doctors Fitzgerald–Pechous, unanimous approval was given to this contribution.

13. The Veterans Program

The report of the Committee on Veterans was read by Secretary Crownhart, and following discussion, it was moved by Doctors Christofferson–Pechous that the report of the committee and its proposals be referred to the House of Delegates for

consideration at the special session in June. The motion as approved read as follows:

Resolved that the report of the Committee on Veterans be referred to the special session of the House of Delegates of the State Medical Society for its action, and for the purpose of taking any position relating to the report which may be deemed appropriate at said session, and that the call for said special session be duly enlarged for this purpose.

A roll call vote showed the following in favor of referring it to the House: Doctors Pechous, Vingom, Spiegelberg, Heidner, Gavin, Beebe, Nadeau, Christofferson, Fitzgerald, Blumenthal, Leahy, and Fidler. Doctors Wilkinson, Arveson, and Ekblad were absent and Doctor Witte chose not to vote. There were twelve in favor, three absent, and one not voting.

14. Secretary's Participation in Advisory Capacity for Other Organizations

Secretary Crownhart stated that he, or members of his office, are frequently asked to participate in the committee structure of other associations or various state bodies. Examples of such participation were outlined. He asked that the Council indicate whether such activity should be continued with the understanding that appointments would be avoided if they would be suitable to the selection of a physician. Upon motion of Doctors Nadeau–Christofferson, the activities of the secretary were unanimously approved.

15. Program for Veterans at the Annual Meeting

Secretary Crownhart stated that the suggestion had been received from Dr. Maurice Hardgrove of Milwaukee that in lieu of the smoker usually held during the annual meeting, a reception be given in honor of returning veterans. He explained that the annual meeting budget would not be sufficient to cover the cost of such a reception and recommended that the Council appropriate funds necessary for the project if it were approved.

Upon motion of Doctors Pechous–Leahy, an appropriation of not more than $1,000 was made for the reception for the servicemen at the next annual meeting. The motion was carried unanimously.

16. Letter from Racine County Regarding the Secretary

Doctor Pechous presented a letter signed by the Executive Board of the Racine County Medical Society, with Dr. E. W. Schacht as president and Dr. Beatrice O. Jones as secretary, with regard to activities of the secretary of the State Society as follows:

RACINE COUNTY MEDICAL SOCIETY
Racine, Wisconsin

E. W. SCHACHT, M. D.
President

BEATRICE O. JONES, M. D.
Secretary
917 Main Street

Copy to Dr. Gavin

March 25, 1946

Members of the Council
The State Medical Society of Wisconsin
Madison 3, Wisconsin

Gentlemen: At a meeting of the Racine County Medical Society held on January 24, 1946, it was voted unanimously to register with the Members of the Council the Society's disapproval of some of the recent actions of Mr. C. H. Crownhart, lay-secretary of the State Medical Society.

The members of the Racine County Medical Society are of the opinion that Mr. Crownhart, a layman employed by the State Medical Society as its Secretary, has a definite assignment to keep the membership informed of important actions prepared by the Society's committees. This is especially true as it pertains to members of the House of Delegates, who represent the actual membership in the formulation of policy. We are also of the opinion that it is of vital importance that the lay-secretary see that adequate time be given to delegates to study proposals and to establish the will of the majority of those represented.

We feel that Mr. Crownhart has failed conspicuously in this assignment within recent months. When The Wisconsin Plan was presented at the meeting of the House of Delegates in October, 1945, a group of members of The State Medical Society were not in accord with the Plan *as presented*, and were therefore asking that further time be granted in order to allow all members of the Society an opportunity to study the Plan. You will recall that the Delegates, themselves, received the material so short a time before the meeting that it was hardly possible for them to give it the study it deserved. Mr. Crownhart had allied himself with the proponents of the Plan and had assisted importantly in the program to insure its acceptance. When made aware of objections to the Plan by a considerable number of the members employing him, he assumed a belligerent attitude and participated in further political action to insure the passage of the measure. Furthermore, it is our opinion that he was guilty of gross official misconduct when, on the floor of the House of Delegates, he sought recognition and spoke in favor of the Plan, urging its immediate passage despite the obvious confusion which existed.

This action exceeded his proper function as a lay-secretary employed by members of the medical profession organized in The State Medical Society of Wisconsin to protect and further their professional interests, as well as those of the public it serves. By his action before the House he has given many of us cause to feel that the State Society has not been given proper representation, or the opportunity for proper analysis of a many-sided program. We further believe that the disunity existing in the State Society is detrimental to the cause of medicine and that Mr. Crownhart, performing as an advocate instead of as a secretary, has been a prime factor in causing further cleavage.

Respectfully submitted,
THE RACINE COUNTY MEDICAL SOCIETY
By the Executive Board
E. W. SCHACHT, M. D., *President*
BEATRICE O. JONES, M. D., *Secretary*

Upon motion of Doctors Christofferson–Heidner, a vote of confidence was extended to the secretary and the chairman of the Council was instructed to reply to the Racine County Society. The motion was carried unanimously.

17. Adjournment

Upon motion of Doctor Christofferson, variously seconded, the meeting adjourned at 2:30 p. m.

C. H. CROWNHART
Secretary

Approved:
S. E. GAVIN
Chairman of the Council

Minutes of the Council, Madison, June 21, 1946

1. Call to Order

The Council was called to order by Chairman Gavin at 7:00 p. m., Friday, June 21, 1946, at the Madison Club, Madison.

2. Roll Call

Councilors present were Doctors Wilkinson, Pechous, Vingom, Spiegelberg, Heidner, Gavin, Christofferson, Arveson, Witte, Fitzgerald, Blumenthal, Leahy, and Past-President Fidler.

Also present were President Minahan, President-Elect Dawson, Speaker Cary, Doctor Neupert, state health officer; Doctor Stovall, delegate to the American Medical Association; Doctor Simenstad, vice-speaker; Doctor Supernaw, chairman of the Committee on Veterans and member of the Council on Medical Service and Public Relations; Doctors Montgomery and Marquardt, members of the Council on Medical Service and Public Relations; and Secretary Crownhart.

3. Order of Business Re Special Session

Secretary Crownhart stated that at the May 26 meeting, the Council acted to recommend to the House of Delegates that its sessions be conducted as executive sessions throughout the proceedings of the special session. The Council then instructed the secretary to forward the call of the House and material relating to Surgical Care not for publication. Since the action of the Council on May 26, one of Wisconsin's newspapers had secured full information concerning the special session and the matters to come before it. Consequently, some of the councilors had suggested that the Council should take action prior to the special session to rescind its recommendation that the House of Delegates conduct its proceedings in executive session.

Following discussion, the following statement was presented on motion of Doctors Heidner–Leahy as a recommendation to the House of Delegates—

"The Council at its meeting on May 26, when it acted to issue a call for a special session of the House, voted at that time to recommend that the House conduct its proceedings in executive session. This action was taken upon the premise that publicity of the various accusations and counter-accusations involving either the legality or the success of the Surgical Care plan of Milwaukee County could result only in unfavorable publicity which would be detrimental to the ultimate success of that plan regardless of such action as might be taken by the House of Delegates upon the petition for the special session. However, it appears that material relative to this matter has been secured by the press and the publicity which the Council sought to avoid has repeatedly been given this matter in considerable detail. For that reason the Council acted yesterday evening to rescind its earlier recommendation favoring an executive session and withdrew the recommendation at that time."

On the basis of a roll call vote, seven were opposed to rescinding the Council's previous action, six were in favor and three were absent. Therefore, the statement was refused approval.

Those who opposed the statement were Doctors Wilkinson, Pechous, Spiegelberg, Christofferson, Fitzgerald, Blumenthal, and Fidler. Those who approved the statement were Doctors Vingom, Heidner, Gavin, Arveson, Witte, and Leahy. Doctors Beebe, Nadeau, and Ekblad were absent.

Secretary Crownhart referred to the Council a suggestion which had been received to the effect that the Council suggest to the House that the reference committees meet consecutively rather than concurrently so as to permit any delegate to attend hearings on either proposal to come before the House and to permit him to appear on either proposal.

Upon motion of Doctors Fitzgerald–Arveson, the following statement was unanimously approved as a recommendation to the House of Delegates.

"The Council believes that both problems before the House are of very considerable interest and importance. It believes that every delegate should have the opportunity to attend reference committee sessions on these matters. It therefore suggests to the House that it instruct the reference committees to meet consecutively rather than concurrently, and to that end the first hearing be conducted by the Reference Committee on Resolutions with the hearings on the report of the Committee on Veterans next to follow."

4. Kellogg Foundation Program Endorsed

Secretary Crownhart presented a letter from the Department of Public Instruction asking for the Society's evaluation of the State School Health Program as financed by the W. K. Kellogg Foundation.

Doctor Neupert, state health officer, recommended active participation and cooperation of the Medical Society in the program of the Cooperative School Health Council which had been working out an educational program in the schools. Doctor Neupert felt that the medical profession should help guide this group as to what should be taught in the schools in the way of health education.

Upon motion of Doctors Arveson–Heidner, the program was unanimously endorsed.

5. Adjournment

The meeting adjourned at 10:45 p. m.

C. H. Crownhart
Secretary

Approved:
S. E. Gavin
Chairman of the Council

Minutes of the Council, Madison, June 22, 1946

1. Call to Order

The Council was called to order by Chairman Gavin, following adjournment of the House of Delegates, at the Hotel Loraine, Madison.

2. Roll Call

Councilors present were Doctors Christofferson, Wilkinson, Pechous, Leahy, Fitzgerald, Spiegelberg, Arveson, Heidner, Witte, Vingom, Blumenthal, Gavin, and Past-President Fidler.

Also present were President Minahan, President-Elect Dawson, Speaker Cary, Vice-Speaker Simenstad; Doctor Stovall and Doctor Sargent, delegates to the American Medical Association; Doctor Supernaw, chairman of the Committee on Veterans; Mr. James O. Kelley, executive secretary of the Medical Society of Milwaukee County; Mr. R. S. Saylor, director of Surgical Care, Milwaukee; Dr. J. W. Fons, secretary of the Medical Society of Milwaukee County; Mr. Francis Lamb and Mr. Robert B. L. Murphy, legal counsel of the State Society; Secretary Crownhart and Executive Assistant Weber.

3. Appropriation for Special Committee on Prepaid Medical Care and Approval of Mr. Weber as Secretary to the Committee

Secretary Crownhart asked for the approval of the Council to draw on the reserve in the medical care insurance account of the Society for the Special Committee on Prepaid Medical Care, authorized by the House of Delegates in special session, and also for approval on having Mr. Ralph Weber, executive assistant, serve as secretary to the special committee.

On motion of Doctors Witte–Fitzgerald, unanimous approval was given to both of these matters.

4. Committee on Veterans Delegated Perfection of Veterans Medical Service Agency with Appropriation of $1,500 for Assistance

Upon motion of Doctors Heidner–Fitzgerald, unanimous approval of the Council was given to appropriating $1,500 from the general funds of the Society for perfecting the establishment of the Veterans Medical Service Agency. In addition, the motion provided that authority be delegated to the Committee on Veterans to perfect the program until such time as an Operating Committee, authorized to direct the agency, could be set up.

The motion received unanimous approval.

5. Adjournment

Upon motion of Doctors Pechous–Leahy, the meeting of the Council was then adjourned.

C. H. Crownhart
Secretary

Approved:
S. E. Gavin
Chairman of the Council

Minutes of the Council, Madison, August 11, 1946

1. Call to Order

The Council was called to order by Chairman Gavin at 9:30 a. m., Sunday, August 11, 1946, at the Madison Club, Madison.

2. Roll Call

Councilors present were Doctors Vingom, Gavin, Christofferson, Arveson, Ekblad, Witte, Blumenthal, Spiegelberg, Wilkinson, Fitzgerald, and Past-President Fidler.

Also present were President Minahan; President-Elect Dawson; Speaker Cary; Doctor Neupert, state health officer; Doctor Stovall, delegate to the American Medical Association; Doctor Rector, member of the Council on Medical Service and Public Relations; Doctor Supernaw, chairman of the Committee on Veterans; Mr. Robert B. L. Murphy, legal counsel for the State Society; Secretary Crownhart; and Assistant Secretary Ragatz.

3. Editorial Statement on Wisconsin and Its Prepayment Plans

Secretary Crownhart stated that in view of the fact that some confusion existed in the state as to the prepayment plans in Wisconsin an editorial statement had been prepared to clarify the matter, and that it would be published in the forthcoming issue of *The Wisconsin Medical Journal*, if the Council approved.

At a later point during the meeting, upon motion of Doctors Vingom–Blumenthal unanimous approval was given to publishing the editorial in *The Journal*. (Printed, as approved in *The Journal*, Aug. 1946.)

4. Report of Committee on Veterans

Doctor Supernaw stated that at the special session of the House of Delegates in June the Council was authorized to create the Operating Committee of the Veterans Medical Service Agency to complete arrangements with the Veterans Administration in Washington and the State Department of Veterans Affairs for the care of veterans.

The fee schedule developed by the Committee on Veterans had been adopted by the Veterans Administration with the exception of two minor changes, prior to the special session of the House, and on August 9 final approval of the contract between the Veterans Administration and the State Medical Society was received.

Mr. Crownhart pointed out that in the contract with the Veterans Administration the key sentence read as follows: "Where the veteran applies for authorization for treatment, such application can be made either through the participating physician or the Veterans Administration. Where the veteran applies for disability rating, such application should be made through the Veterans Administration."

Two resolutions were presented for Council consideration, one of which was authority to execute the contract and the other of which related to the operation of the Veterans Medical Service Agency. The two resolutions follow:

WHEREAS, the House of Delegates of the State Medical Society of Wisconsin, in special session assembled on June 22, 1946, did by resolution authorize the creation by the Council of a new agency of the Society to be known as Wisconsin Veterans Medical Service Agency, such Agency to have full powers to contract or to do whatever else is deemed requisite for the development of a program for the examination, treatment, and counseling of veterans of the armed forces of this country eligible for such professional services, and

WHEREAS, subsequent to such special session, the Veterans Committee of this Society has negotiated with Veterans Administration and the Wisconsin State Department of Veterans Affairs to the end that each such organization might deal with members of the State Medical Society through said Veterans Agency rather than to deal with such physicians individually;

Be it therefore resolved:

1. The chairman and secretary of the Council and the chairman of the Operating Committee be and are hereby authorized to execute a contract with the Veterans Administration on behalf of the Wisconsin Veterans Medical Service Agency as an agency of the Society, with continuing authority to execute such modifications of and amendments to such contract as may from time to time be necessary or desirable.

2. The chairman and secretary of the Council and the chairman of the Operating Committee be and are hereby authorized to execute a contract with the State Department of Veterans Affairs on behalf of the Wisconsin Veterans Medical Service Agency as an agency of the Society, with continuing authority to execute such modifications of and amendments to such contract as may from time to time be necessary or desirable.

WHEREAS, the House of Delegates of the State Medical Society of Wisconsin, in special session assembled on June 22, 1946, in recognition of its professional responsibility toward veterans of the military forces of this country, authorized the establishment of the Wisconsin Veterans Medical Service Agency by the Council of this Society, so as to assure on the highest professional level an adequate program for the physical examination, treatment and medical care of veterans; and

WHEREAS, since the date of such special session the Committee on Veterans has negotiated with the Veterans Administration and the Wisconsin State Department of Veterans Affairs to the end that a plan might be developed in which the Society would participate through the Veterans Agency for handling the treatment and care of veterans in need of medical services on a basis calculated to serve the best health interests of said veterans;

Be it resolved:

1. The chairman of the Council be hereby authorized to appoint five members of this Society to serve as the Operating Committee of the Veterans Agency, such appointments to be geographically representative of the distribution of the profession throughout the state. The term of such appointments shall be for five (5) years; provided that the initial appointments shall be for terms of one (1), two (2), three (3), four (4) and five (5) years respectively.

2. The Operating Committee shall be vested with those powers necessary to carry out contractual obligations and commitments of the Society relating to such agency subject to established Society policies and procedures.

3. The position of executive director of the Veterans Agency be herewith authorized at a salary up to $450 for the first six months and a salary up to $500 after such period.

4. The Veterans Agency be authorized to work out with the Wisconsin Hospital Association the latter's formal request that it be given representation in any arrangements made with the Veterans Administration or the State Department of Veterans Affairs.

5. The treasurer of the State Medical Society is herewith authorized to set over by way of advances, sums from the Society's reserves up to an aggregate of $10,000 to enable the Veterans Agency to begin operations, it being understood that such advances will be repaid to the Society reserve out of Veterans Agency overhead income over such period of time and at such rate as may be found financially practicable.

Secretary Crownhart explained that an estimated budget had been drawn up for the first four months of operation of the Veterans Agency, predicated upon the fact that for the first sixty days, the agency would not be in actual operation but would be engaged in setting up the office, installing telephones, obtaining necessary forms, and the like. The next sixty days the agency would be in actual operation but in its initial development would not be handling government funds with which to reimburse physicians. There would, therefore, be a period of about 120 days during which the agency would not be able to sustain its operating expense, and the advance of $10,000 authorized by the second of the two resolutions listed above would carry the agency over this period.

A representative of the State Department of Veterans Affairs would be located in the agency office and would be empowered to authorize charges against the state funds. Likewise, a representative of the Veterans Administration would have space in the agency office and would be empowered to issue authority for treatment against the Veterans Administration.

Upon motion of Doctors Arveson–Christofferson, the first resolution authorizing execution of the contract with the Veterans Administration and the State Department of Veterans Affairs was approved unanimously.

Upon motion of Doctors Arveson–Christofferson, the second resolution, providing for the appointment of an Operating Committee for the Veterans Medical Service Agency, its powers, authorizing the

position of executive director, and providing an appropriation of $10,000 from Society reserves for initial operation of the agency pursuant to the estimated budget, was unanimously carried.

Doctor Dawson, as a member of the board of the State Department of Veterans Affairs, suggested that the membership of the Advisory Committee to that department be increased by two because of the increasing volume of work being handled by that committee.

Upon motion of Doctors Blumenthal–Christofferson, unanimously carried, the membership of the Advisory Committee to the State Department of Veterans Affairs was increased by two.

5. Authorization for Additional Society Employee

Secretary Crownhart stated that at present the central office was not adequately staffed to handle the volume of work confronting it and as a result many of the staff members were putting in considerable overtime.

Upon motion of Doctors Witte–Vingom, the secretary was unanimously authorized to employ an additional stenographer.

6. Certificate of Service Authorized for Procurement and Assignment Consultants

The suggestion of Dr. Frank H. Lahey, national chairman of Procurement and Assignment Service, was referred to the Council for consideration. Doctor Lahey, in a letter to all state medical societies, suggested that state committee members be commended by their state societies. After conference with Doctor Fitzgerald, state chairman in Wisconsin, a form of certificate of service was drafted for signature by the chairman of the Council, the state chairman, and presidents of the Society during the years of World War II.

Upon motion of Doctors Witte–Christofferson, authorization was given to the preparation of such a certificate for Procurement and Assignment consultants. The motion was carried, but not unanimously.

7. Secretary's Travel Account Increased by Transfer

Secretary Crownhart explained that due to an increased amount of travel during this year, entailed by attendance at the A. M. A. meeting at San Francisco, meetings of the National Physicians Committee, required conferences at Washington, and the like, his travel account had been expended to the limit budgeted. In view of the fact that other meetings were scheduled in the future, it was suggested that a transfer of $750 from the industrial health account be made to the secretary's travel account.

Upon motion of Doctors Vingom–Blumenthal, this transfer was authorized unanimously.

8. Transfer Authorized for Special Committee on Prepaid Medical Care

Secretary Crownhart reminded the Council that authorization was granted at the June 22 Council meeting to draw on the budgeted fund for voluntary sickness insurance to the extent of $2,000 to support activities of the Special Committee on Prepaid Medical Care set up by the House of Delegates. It now seemed apparent that an additional appropriation amounting to $2,000 would be required so that in all $4,000 would be available for the work of this committee.

A considerable amount of the travel expense of Mr. Weber would be carried from this account. The expenses of attorneys and of committee members and committee meetings would also be carried from this account. In addition, the committee had asked for a certified public accountant audit of the Milwaukee plan so that accurate data could be available to the House of Delegates in October.

It was suggested that this amount be transferred from the reserve in industrial health. Upon motion of Doctors Christofferson–Blumenthal, unanimous approval was given to this transfer.

9. Transfer Authorized for Accounting Services

Secretary Crownhart explained briefly the accounting procedures of the office, and stated that it would be necessary for the Society to have consolidated records to tie in the Veterans Medical Service Agency and other agencies of the Society. It would be necessary to file income tax reports, Social Security deductions, and records for compensation insurance in a consolidated form for all of the agencies.

This matter had been reviewed by lawyers and the certified public accountant who assists the Society, and it was felt necessary that the accounting system of the Society be revised as of January 1 to handle the more complex nature of these procedures.

A transfer of $500 was asked from the panel account to the budget allocation for accounting so that these accounting procedures might be developed and effective as of January 1, 1947, such procedures to be approved by the Council at a later meeting.

Upon motion of Doctors Witte–Ekblad, unanimous approval was given to transfer of $500 from the panel account to the budget allocation for accounting.

10. Transfer Authorized for Legal Services

Secretary Crownhart explained that the Committee on Mental Hygiene and Institutional Care and the special committee of the president, the Committee on Incurably Ill, had met with a committee of the County Judges Association and had proposed a most important legislative project relating to the care of the aged, the infirm, and the permanently disabled. An outcome of their discussions will be the development of legislation of a technical character inasmuch as it will affect the present system of state aid.

This project will be an addition to the regular activities of the Society and will necessitate considerable legal services in its development. A transfer of $500 was suggested from the industrial health operating reserve to the legal services account.

Following discussion, it was moved by Doctors Arveson–Dawson that the transfer be approved, and unanimous approval was given.

11. Advisory Committee on Fee Schedules Authorized

Inasmuch as there were four or five fee schedules in operation on a state-wide level, it was suggested that it would be advisable to consider creating a five-member special committee on fee schedules which in turn might consider the development of a uniform fee schedule for utilization with governmental agencies.

Upon motion of Doctors Arveson–Ekblad, the chairman was unanimously authorized to appoint such a committee.

12. Nursing Problem

The following resolution received from the Eleventh Councilor District was presented to the Council for consideration:

The Eleventh Councilor District meeting on July 18, 1946, in executive session, passed a resolution unanimously to be presented to the Council of the State Medical Society condemning the current trend in nursing education in Wisconsin.

While recognizing the value of advanced standards of nursing education, it is felt that when those advanced standards are forcing the closing of smaller hospital training schools and thus interfering with the production of sufficient nurses to adequately take care of the sick, then such advanced standards should be modified to meet the situation.

If such modification of standards is not voluntarily taken by the State Board of Nursing, then it is recommended by this same resolution that proper legislative action by the State Medical Society be instituted to bring about such action.

Following discussion, the following resolution was unanimously passed upon motion of Doctors Ekblad–Spiegelberg:

WHEREAS, it is apparent that the distribution of trained nurses in Wisconsin is not adequate to the urgent need of its people, and that this results in part from a similarly poor distribution of training schools, and

WHEREAS, the availability of trained nurses is essential to the public health interest of the people, and

WHEREAS, the present state educational and licensing body is virtually independent of the State Board of Health of which presumably it is a part, and

WHEREAS, it may be possible to develop a more realistic approach both to the problem of educating the nurse, securing a greater number of qualified applicants, and encouraging the development of more training schools with a wider distribution within the state, and

WHEREAS, the State Board of Health as the official state agency charged with responsibility in the field of the public health of this state, is the logical state agency to develop such a program,

Be it resolved, that the Council of the State Medical Society suggest to the Committee on Public Policy that it consider the feasibility of preparing for submission to the House of Delegates at the annual meeting in 1946, proposed legislation providing that the Committee on Nursing Education and the Bureau of Nursing be reconstituted as official divisions of the State Board of Health, with their actions and recommendations subject to its approval as is now true with reference to its other divisions.

13. Committee on War Records

Assistant Secretary Ragatz presented the report of the Committee on War Records, containing a recommendation that a complete record of the war service of all Wisconsin physicians be compiled for publication as early as possible in 1947. This record would include the service of physicians "on the home front" who assisted the war effort.

Upon motion of Doctors Wilkinson–Ekblad, unanimous approval of the Council was given to the activities of the Committee on War Records in compiling a complete record of service for Wisconsin physicians.

Following discussion, upon motion of Doctors Witte–Ekblad, unanimous approval was given to preparing a brochure containing complete service records of Wisconsin physicians, as outlined by the Committee on War Records.

14. Cooperative Health Legislation

Secretary Crownhart reviewed for the Council efforts of the cooperative groups in Wisconsin at the 1945 legislative session at which time they sought to attach to the enabling act of the medical societies a measure which would have given them the authority to employ physicians on a salary or other basis and to retail the services of those physicians to the members of a cooperative on a prepayment plan.

The State Society's position with reference to that proposed amendment was that the law pertained to the powers of medical societies, that the amendment which the cooperatives were attempting to attach pertained to the powers of cooperatives, and that it raised an independent issue from that raised by the medical societies. The amendment was defeated.

In view of recent claims of the cooperative organizations that the medical societies had established virtually a medical monopoly on prepayment insurance and that cooperatives were fenced out, a member of the Wisconsin Assembly wrote to Commissioner Morvin M. Duel of the Department of Insurance for clarification of the problem.

In reply to this inquiry Commissioner Duel stated as follows:

Your recent inquiry as to the legal status of co-ops under the Wisconsin insurance laws is one of a number recently received on this subject. Because of the apparent confusion which exists, I think it may be helpful to clarify a few fundamental points. Co-ops, by which I mean cooperative associations organized under Chapter 185 of the Wisconsin Statutes, which are interested in doing insurance business have always been subject to the insurance statutes of this state. The 1945 legislature made no changes in this respect. There are now several organizations in this state which deal almost exclusively with cooperative groups organized and authorized to write insurance in such diverse fields as automobile, fire and life insurance. Each of these cooperative insurance companies was required to fulfill all the obligations imposed by law for ordinary insurance companies, and they have all done so in fact.

In answer to your second question, I must answer in the negative, because so far as I can determine, that enabling act had no concern whatever with co-ops. This law, relating as it does to the establishment of sickness care plans by state or county medical societies was enacted in part as an amendment and in part as an addition to Chapter 148 of the Statutes, entitled "Medical Societies." The act does not even mention co-ops at any point, nor would it have seemed appropriate to the writer to have had any provisions relating to co-ops in a Medical Society statute.

In answer to your third point, this is a question of public policy. I call your attention, however, to Section 180.32 of the Wisconsin Statutes, which is the enabling act for Wisconsin Blue Cross. It is reasonable to consider a hospital service plan and a sickness care plan established by a medical society as falling within the same general category. Each of these is a non-profit service organization. One has special resources assuring the delivery of hospital service and the other for assuring medical care.

It should also be noted in answer to your fourth question that the enabling act requires that any prepaid sickness care plan established under Chapter 148 is subject to insurance statutes relating to non-discriminatory rates, investment of funds, and premium reserves, and that any new or modified existing plan, and specimen copies of all contracts must be filed with the Commissioner of Insurance.

In answer to your fifth question, no matter how simple an insurance business appears to the uninitiated, the fact remains that it is a highly involved matter these days whether from the standpoint of contracts, selection of risks, reserves or investments. I cannot say with too much emphasis that insurance laws are designed not as obstacle courses for prospective promoters of new companies, but as essential protection for the public which buys insurance, and which is entitled to a maximum for its money.

15. House of Delegates Minutes to be Summarized in *Journal*

Advice of the Council was sought as to whether the full transcript of the House of Delegates meeting in June should be published in *The Journal* or whether the minutes should be published in summary form.

Upon motion of Doctors Blumenthal–Christofferson, unanimously carried, the secretary was instructed to summarize the House of Delegates minutes for *The Journal.*

16. Report of Conference Committee on Open Panel Approved

The report of the Conference Committee on Open Panel was presented to the Council for its consideration. Upon motion of Doctors Blumenthal–Christofferson, the report of the committee was unanimously approved for inclusion in the Council report to the House of Delegates.

17. Report of the Committee on School Health Approved

The report of the Committee on School Health was presented to the Council for its consideration. Upon motion of Doctors Ekblad–Christofferson, the report of the committee was unanimously approved for inclusion in the Council report to the House of Delegates.

18. Report of the Advertising Advisory Committee Approved

The Advertising Advisory Committee report was considered by the Council, and upon motion of Doctors Vingom–Blumenthal, the report of the Advertising Advisory Committee was unanimously approved for inclusion in the Council report to the House of Delegates.

19. Residency or Research Membership

Secretary Crownhart explained that there is a provision in the By-Laws under which a physician may be elected to residency or research membership wherein he pays $5 a year to his state and county societies combined. Membership in that classification is for three years. It had been construed by the secretary's office that if a member so elected is elected so that his term under that classification expires during the course of the year, his membership terminates at that point and he must submit to regular election and then pay prorated dues for as much of the year as remains. Advice of the Council was sought.

Upon motion of Doctors Spiegelberg–Blumenthal, unanimous approval was given to the manner in which the By-Law was construed by the secretary's office.

20. Honorary Membership for Doctor Belitz Held Over

Recommendation had been submitted to the Council that Dr. A. E. Belitz of Pepin be considered for honorary membership. Inasmuch as Doctor Arveson, councilor from that district, had left the meeting, the motion was made by Doctors Blumenthal–Vingom, unanimously carried, that the matter be held over until the next meeting of the Council.

21. Veterans Program Publicity

Doctor Supernaw requested that no publicity be given to the establishment of the veterans program until it would be released by the Operating Committee of the Veterans Medical Service Agency, inasmuch as at least two months would be needed to get procedures under way. If publicity would be withheld for at least sixty days, the burden on individual physicians would be eased as well as on the agency itself.

Upon motion of Doctors Vingom–Blumenthal, unanimously carried, the secretary's office was instructed to withhold information on the veterans program until the appropriate time for release of publicity.

Adjournment

The Council adjourned at 3:00 p. m.

C. H. Crownhart
Secretary

Approved:
S. E. Gavin
Chairman of the Council

Minutes of the Council, Milwaukee, October 6, 1946

1. Call to Order

The Council was called to order by Chairman Gavin at 1:30 p. m., Sunday, October 6, 1946, at the Hotel Schroeder, Milwaukee.

2. Roll Call

Councilors present were Doctors Wilkinson, Vingom, Spiegelberg, Gavin, Beebe, Nadeau, Christofferson, Arveson, Ekblad, Witte, Fitzgerald, Blumenthal, Heidner, and Past-President Fidler.

Also present were President Minahan; President-Elect Dawson; Speaker Cary; Vice-Speaker Simenstad; Treasurer Sisk; Doctor Gundersen, president of the State Board of Health; Doctor Neupert, state health officer; Doctor Stovall, delegate to the American Medical Association; Doctor Supernaw, chairman of the Operating Committee, Veterans Medical Service Agency; Doctor Neidhold, chairman of the Council on Scientific Work; Doctor Tenney, chairman of the Wisconsin Child Health Study; Doctor Kurten, Racine; Mr. T. J. Doran, director of the Veterans Medical Service Agency; Mr. Robert Murphy, legal counsel; Secretary Crownhart; Assistant Secretary Ragatz; and Executive Assistant Weber.

3. Minutes of Previous Meetings

Secretary Crownhart stated that because of the great amount of secretarial work involved in preparing for the special session of the House of Delegates, as well as the regular session, and special committee meetings, it had been impossible to prepare the minutes for the May 26, June 21 and 22, and August 11 meetings of the Council. The minutes for those meetings, as well as the present one, would be prepared for publication in the December, 1946, *Wisconsin Medical Journal.*

4. Report of the Committee on Audit and Budget

Doctor Christofferson, chairman of the Committee on Audit and Budget, presented the report of his committee as follows; and upon motion of Doctors Fitzgerald–Blumenthal, it was accepted unanimously.

Committee on Audit and Budget

The Committee on Audit and Budget is composed of Dr. H. H. Christofferson, Colby, chairman; and Drs. R. W. Blumenthal, Milwaukee; A. T. Nadeau, Marinette; C. O. Vingom, Madison; and J. F. Wilkinson, Oconomowoc. It met in the offices of the State Medical Society in Madison, on Sunday, September 15. The president of the Society was present also, as was the president-elect during part of the meeting. Doctor Wilkinson was unable to attend.

Members of the committee inspected the office facilities and mechanics, and met with various members of the office staff, including Miss Brandt, Mrs. Davis whose assignment is in the radio and news work, Miss Kracht of the membership record department, and Mrs. Atkinson, assistant editor of *The Journal.* The committee was impressed with the volume of work being carried out in the office, particularly in view of cramped office facilities.

An itemized audit of all bills, checks and check stubs was then made of the year 1945. Expenditures were scrutinized to make certain that the budget established had been followed substantially. While some items were overexpended, these were minor and of no concern. A number of budgetary allotments showed unexpended balances, due to carry-over appropriations built up as activities were shifted during war years from an annual to an eighteen month basis. The total available for expenditures was $88,500 with actual expenditures amounting to $65,803.35. Cash carry-over into the next fiscal year totalled approximately $22,000.

The committee was given a certificate of bonds on hand as of the last of 1945. Their trust fund calibei speaks well of the care of our treasurer. After the anniversary meeting in October, when dues are established, the committee will prepare a budget for 1947.

5. Report of Veterans Medical Service Agency

Doctor Supernaw in his report on progress of the Veterans Medical Service Agency stated that Dr. H. S. Fuson of Eau Claire and Dr. F. D. Weeks of Ashland had been appointed as the two additional members of the Operating Committee to serve with Dr. Maurice Hardgrove of Milwaukee, Dr. W. C. Finn of Fond du Lac, and himself in developing the agency.

The Operating Committee had formally approved all forms and an initial letter to be sent to all members of the Society with regard to the program, and this material had been mailed to the membership.

Doctor Supernaw further stated that office space had been secured for the agency in the Washington Building at Madison, and that while a handbook would be sent out to the membership setting forth details of the plan, actual operation would not begin until about November 1.

Requests had been received from the Wisconsin Hospital Association and from the nurses for representation in the agency. Meetings had been held with representatives of these groups as well as with the men from the Veterans Administration and State Department of Veteran Affairs. This group was referred to as the General Committee and in the future would consist of those who participate in the activities of the agency. The Operating Committee, however, would establish policies, handle complaints, act as the disciplinary body, and as the liaison between the medical profession and the governmental agencies.

Mr. Thomas J. Doran, director of the agency, was introduced to the Council as the direct representative of the medical profession in its contacts with the other agencies.

Doctor Supernaw pointed out that veterans coming to the doctor's office would come under one of three classifications:

1. He has service-connected disability.
2. His case involves emergency and want or distress.
3. He is a private patient.

Authority for treatment is granted in the first case through the Veterans Administration and in the second case by the State Department of Veterans Affairs, with the doctor requesting such authority through the Veterans Medical Service Agency. If the patient is ineligible under either of these two cases, he becomes a private patient.

When authority for treatment is received by the physician, he submits his bill to the Veterans Medical Service Agency which in turn sends the physician a check to cover his services as outlined in the approved fee schedule. Complete details are contained in the handbook distributed to the membership.

6. Report of the State Health Officer

Doctor Neupert presented a report on his attendance at various national and regional meetings and his conception of trends in public health. In this connection Secretary Crownhart presented a resolution referred to the Society by the American Medical Association, asking that it be considered by the Society's Council and House of Delegates. The resolution called for the development, as rapidly as possible, of complete territorial and population coverage in the continental United States with modern full-time public health organizations on a county, joint county, or district basis.

Upon motion of Doctors Ekblad–Nadeau, unanimous approval was given to placing this resolution before the House of Delegates.

7. Regular Army, Navy, or Public Health Service Officers to Pay Dues

Secretary Crownhart stated that some physicians who were in wartime service have accepted career appointments in the Army, Navy, or Public Health Service. Advice of the Council was sought as to whether dues should be paid by these physicians, following their acceptance of career appointments.

Upon motion of Doctors Nadeau–Blumenthal, unanimously carried, the secretary was instructed to inform physicians who accepted career appointments that they must pay the regular Society dues to maintain membership in the State Medical Society of Wisconsin.

8. Dues Assessment

The question was referred to the Council as to whether the policy should be continued as established some years ago of not permitting a member to rejoin if he dropped membership in a year in which a special assessment was levied unless he paid the special assessment for that year.

Upon motion of Doctors Blumenthal–Vingom, unanimously carried, this policy was continued.

9. Use of Society's Addressograph

Assistant Secretary Ragatz stated that the Society's office is frequently called upon for the use of its Addressograph plates in connection with various circulations proposed to members. Occasionally, requests have been made by members of the Society for mailing special announcements concerning opening of offices, limiting practice, and so forth. In these cases, the Society has advised the physician that approval to this procedure should be given by the county secretary so that no questions of ethics may be involved.

In matters pertaining to purely commercial ventures, except in the case of advertisers or exhibitors, where a nominal charge for service is made, the use of the Addressograph has been refused.

The Council was asked to give consideration to this matter. Upon motion of Doctors Vingom–Ekblad, unanimously carried, the Council determined that the Addressograph and plates should be used only for official business of the Society.

10. 4H Club Program Approved

Assistant Secretary Ragatz reported that a request had been made by the 4H Club that the Society assist in the development of a new type of program for an award to one boy and one girl Club member each year for progress in health achievements. The Committee on Rural Health and Accident Prevention had recommended cooperation of the Society in this respect and an annual appropriation of $125 to $150 to help finance a trip for the boy and girl chosen to represent the state at the National Congress in Chicago.

Upon motion of Doctors Fitzgerald–Heidner, unanimous approval was given to the support of this program and to an appropriation not to exceed $150, with the matter to be referred to the Committee on Rural Health and Accident Prevention for action.

11. Life Membership Approved for Doctor Belitz

Dr. A. E. Belitz of Pepin was born July 2, 1866; graduated from the College of Physicians and Surgeons, Chicago, in 1895; was licensed to practice medicine in Wisconsin in 1901; and has been a continuous member of the Society from 1903, when he began practice in Milwaukee. On recommendation of Doctor Arveson, councilor from the district, a motion was made by Doctors Wilkinson–Nadeau, unanimously approved, that life membership be granted Doctor Belitz.

12. Report on Wisconsin Child Health Study

Doctor Tenney, chairman of the Wisconsin Child Health Study, in his report on the progress of the study, stated that while material was being gathered from all over the state, it would be necessary for the State Medical Society, the State Board of Health, and various other agencies to see that the material is analyzed and made useful. At present no standards of a statistical nature are being computed, but questionnaires have been sent out to doctors and hospitals throughout the state and replies have been received from about 50 per cent. It was hoped that the necessary 60 per cent could be reached for statistical analysis.

13. High School Debates

Secretary Crownhart reported that numerous requests were being received from high school debate

groups for material on sickness insurance inasmuch as the subject had been chosen by the State Forensic Association for debate this year. Fifty loan packets had been developed for distribution to those who requested information on sickness insurance. In addition, reprints of a summary of Mr. George Crownhart's book entitled "Sickness Insurance in Europe" had been prepared for distribution as well as for publication in the *Wisconsin Medical Journal.*

Following discussion, upon motion of Doctors Vingom–Fitzgerald, unanimously carried, the matter was referred to the Council on Medical Service and Public Relations for action.

A further report was made by the secretary on the results of a trip made to radio stations and newspaper offices by Mrs. Mary Davis, staff member in charge of the radio programs and news releases.

14. Section on General Practice of Medicine

Consideration of the Council was given to a resolution forwarded by Dr. George F. Lull, secretary and general manager of the American Medical Association, relating to the creation of a Section on the General Practice of Medicine. This resolution had been adopted at the San Francisco meeting of the American Medical Association in July. Doctor Lull requested that consideration be given to the recommendation contained in it.

Upon motion of Doctors Fitzgerald–Arveson, unanimously carried, the resolution relating to the Section on General Practice was referred to the House of Delegates.

15. Interscholastic Football Competition in Junior High Schools

The Committee on School Health referred to the Council a resolution providing that the Council record itself in opposition to a program of interscholastic football competition in the junior high schools.

Upon motion of Doctors Ekblad–Blumenthal, unanimously carried, the resolution was referred to the House of Delegates for action.

16. Meeting of Associated Medical Care Plans

Secretary Crownhart reported on the meeting of the Associated Medical Care Plans held in Chicago on October 4 and 5. That organization has the sponsorship of the American Medical Association and brought into a round-table conference, for mutual aid and benefit, the various prepaid medical care plans in the country.

Among the items discussed at that meeting were the various veterans care programs throughout the country.

Secretary Crownhart stated that there were eighty-four plans in thirty-three states, involving prepaid medical care insurance, with a coverage estimated by the A. M. A. to be 2,845,000.

Considerable discussion was given to the difficulty of prepaid plans to provide coverage of interstate groups, because of the inability to provide uniform benefits, uniform rates, common application forms, and the like.

The director of the California plan, which has an enrollment of approximately 300,000, reported that the great problem in his state was the education of the medical profession. As a result an extensive program is being carried out in that state to acquaint the doctors and their office girls with the forms used, how to fill them out, and the relationship of the plan to the people.

The question was debated as to whether plans of the type of the Wisconsin Plan should be admitted to full voting membership in Associated Medical Care Plans, have a part in its deliberations, secure the benefit of experience of other plans, and the like.

Following extensive discussion, on an advisory vote of the plans present, fourteen plans voted for the admission of the Wisconsin Plan, and nine voted against.

Information was disclosed at the meeting that the A. M. A. had had conferences with insurance companies at which several subcommittees were appointed, one of which, representing the A. M. A., is to work with the various insurance associations toward the development of a uniform schedule of benefits on a unit basis.

17. Resolution Commending A. M. A. Council on Medical Education and Hospitals

Doctor Beebe presented a resolution commending the Council on Medical Education and Hospitals for its work and urging that Council to continue its important activities so that it will be recognized generally as the one proper organization in this country to standardize hospitals.

The Council requested that this resolution be included in the supplementary report of the Council to the House of Delegates.

18. Racine County Letter

Doctor Gavin presented a letter received from the Racine County Medical Society asking if any action had been taken in regard to its previous letter registering disapproval of the secretary's activities at the 1945 House of Delegates meeting in connection with the Wisconsin Plan.

Action taken at the May 26 meeting was reviewed at which the chairman was instructed to reply to the Racine County Society and at which a vote of confidence was extended to the secretary.

Inasmuch as minutes of the May 26 meeting had not been published at the date of this session, the reply had been delayed.

19. Adjournment

The Council adjourned at 4:15 p. m.

C. H. Crownhart
Secretary

Approved:
S. E. Gavin
Chairman of the Council

Minutes of the Council, Milwaukee, October 8, 1946

1. Call to Order

The Council was called to order by Chairman Gavin at 2:00 p. m., Tuesday, October 8, 1946, at the Hotel Schroeder, Milwaukee.

2. Roll Call

Councilors present were Doctors Vingom, Christofferson, Spiegelberg, Beebe, Ekblad, Heidner, Pechous, Arveson, Nadeau, Gavin, Leahy, Truitt, and Witte.

Also present were President Dawson; President-Elect Stovall; Speaker Gundersen; Doctor Neupert, state health officer; Doctor Tenney, chairman of the Wisconsin Child Health Study; Doctor Fons, a member of the Operating Committee, Wisconsin Physicians Service; Doctor McGill, Superior; Doctor Jegi, Galesville; Doctor Christensen, Wausau; Mr. Wheeler and Mr. Nauert of Associated Hospital Service; Messrs. Murphy and Lamb, legal counsel for the Society; Secretary Crownhart; and Executive Assistant Weber.

Chairman Gavin introduced Doctor Truitt, new councilor from the Twelfth District.

3. Purpose of Meeting

Secretary Crownhart outlined the matters which were referred to the Council for consideration as a result of House of Delegates action. These matters were as follows:

a. A recommendation that the Council by resolution authorize the treasurer of the Society immediately to set aside the sum of $25,000 for the purposes of the special committee relative to Wisconsin Physicians Service, to aid that committee in any manner in which it sees fit. Further, that the $25,000 be appropriated with the understanding that if experience permits, it will ultimately be returned to the Society; and if the amount appropriated should prove insufficient, the committee would bring in its own report to the Council and seek a further appropriation.

b. A recommendation of the secretary's office that the Council authorize Mr. Weber, executive assistant of the Society, to be loaned to Wisconsin Physicians Service from December 1 for a six-month period without any charge to Wisconsin Physicians Service, so that he could devote his full time to the promotion and development of Wisconsin Physicians Service. At the end of the six-month period, the recommendation of the Operating Committee would be sought as to the future program.

c. Under the present law by which Blue Cross operates in the State of Wisconsin, there is a provision that all physician members shall be approved by the State Medical Society of Wisconsin. When the divorcement proceedings were undertaken in 1940, the Society instructed the secretary's office to advise Blue Cross formally that it waived its rights to approve the physician members to that organization. Under the program presented by the majority report adopted by the House of Delegates, it is contemplated that Blue Cross will be working with medicine in the state in the sale of prepared medical care insurance. It seemed only proper, therefore, that the Society approve the physician members of Blue Cross and grant its cooperation to that organization.

d. The Society now sponsors the Wisconsin Plan, carried through commercial insurance carriers. Effective December 1, the Society will sponsor Wisconsin Physicians Service as the Society's own agency, providing insurance on a service basis. At present, the Society is also sponsoring the Veterans Medical Service Agency. Every physician in the Society should be informed in detail as to these programs and the fact that they are supported by the State Medical Society of Wisconsin to the limit of its ability. For that reason, the secretary recommended that the Council authorize him to prepare at an early date, recommendations for the creation in the office of the State Medical Society of a Division of Public Relations which would carry equally, equitably, and efficiently to the public of this state the attitude of medicine with respect to these programs and would correlate the publicity that may emanate through the secretary's office or in the *Wisconsin Medical Journal*, so that none of it could be held to be preferential for one plan as against another.

e. A recommendation that the deans of the two medical schools in the state be requested by the Council to attend the Council meetings whenever possible, or designate a representative of their respective faculties to do so.

f. A recommendation that the speaker of the House of Delegates, at the earliest feasible date be asked to designate the reference committees which will serve at the ensuing annual session, and that those reference committees be so advised and of the reports that will be referred to them. Thus, the reference committees would be encouraged to follow the work of the Council and the various committees more closely than they might otherwise. In addition, it was recommended that the chairmen of the reference committees be invited routinely to join the Council at all of its meetings.

4. Appropriation to Wisconsin Physicians Service

Upon motion of Doctors Pechous–Leahy, unanimously approved, an appropriation of $25,000 was authorized for the Wisconsin Physicians Service as outlined in item 3a above.

5. Mr. Weber Loaned to Wisconsin Physicians Service for Six Months

Upon motion of Doctors Arveson–Nadeau, unanimously carried, the Council approved loaning Mr. Weber to the Wisconsin Physicians Service for a six-month period, as outlined in item 3b above.

6. Physician Members of Blue Cross

The physician members of Blue Cross are elected by the staff of each participating hospital, and if the hospital has no organized staff, they are elected by the hospital. Blue Cross at the present time has fifty participating hospitals, each of which selects one physician and three others to be members of the corporation so that each hospital has four members of the corporation, one of whom is a physician. With fifty participating hospitals, the membership of Blue Cross is roughly 200 members. The membership elects the Board of Directors in the same proportion with respect to physicians as is true with each individual hospital, so that of the Board of Directors, one out of every four is a physician.

Under the law, as explained in item 3c above, the State Medical Society has the privilege of approving the physician members so selected by each staff.

Mr. Wheeler, executive secretary of Blue Cross, stated that on October 28 the annual meeting of the Blue Cross organization would be held. At that time or immediately after that meeting, a complete and up-to-date list could be submitted for approval.

Upon motion of Doctors Vingom–Heidner, unanimous approval was given to having the Council approve the physician members of Blue Cross.

7. Division of Public Relations Discussed

As outlined in item 3d above, the secretary asked for authority to develop as rapidly as possible a recommendation and a specific means of operating a Division of Public Relations in the State Medical Society. In the meantime, until a specific program could be developed, the secretary asked for authority to contact every county medical society and, under the direction of the various interested divisions, provide a method of carrying to each county medical society the importance of these several programs.

Upon motion of Doctors Christofferson–Arveson, unanimously carried, the secretary was instructed to accumulate such information and bring it before the Council at its next meeting so that a definite program could be developed.

Upon motion of Doctors Ekblad–Heidner, unanimously carried, the secretary was instructed to contact all county medical societies to arrange programs in each at which representatives of the State Medical Society may present a full report of the House of Delegates meeting and what is proposed for the future.

8. Deans of Two Medical Schools to be Invited to Council Meetings

As outlined in item 3e above, upon motion of Doctors Leahy–Christofferson, unanimously carried, the secretary was instructed to invite to all Council meetings the deans of the two medical schools in the state with the request that if they cannot attend, they designate a representative of their faculties to do so.

9. Appointment of Reference Committees and Invitation to Chairmen Held Over

The recommendation outlined in item 3f above was discussed at length, and it was the request of the Council that it be held over until the next meeting.

10. Contingent Approval Given to Blue Cross for Literature

Mr. Wheeler of Blue Cross stated that while no contract now exists between the Blue Cross organization and the State Medical Society, if such contract should be executed and Blue Cross sells Wisconsin Physicians Service in the future, the Blue Cross organization would be interested in presenting its literature to the public on a comparable basis to that under which the insurance companies participating in the Wisconsin Plan are permitted to do so. In other words, if a contract is executed between Blue Cross and the State Medical Society for the sale of Wisconsin Physicians Service, Blue Cross would like to use the same or similar endorsement used under the Wisconsin Plan.

Following discussion, the motion was made by Doctors Heidner–Christofferson and unanimously carried that contingent upon the signing of a contract with Blue Cross the Council would give permission to the Operating Committee of Wisconsin Physicians Service to add such statement on the literature which would indicate that the Wisconsin Physicians Service and Blue Cross have the approval of the State Medical Society of Wisconsin.

11. Members of Special Committee on Prepaid Medical Care are Members of Operating Committee of Wisconsin Physicians Service

One of the members of the Operating Committee asked to be relieved of his duties in that connection because of his increased responsibilities as a newly elected officer of the Society. It was suggested that inasmuch as the House of Delegates had accepted the majority report of the Special Committee on Prepaid Medical Care only a few hours previous providing that the Special Committee become the Operating Committee of Wisconsin Physicians Service, such action should be withheld at this time.

A member of the Operating Committee residing in Milwaukee County questioned the status of the three physicians residing in that county as members of the Operating Committee of Wisconsin Physicians Service. The substance of point raised was that they had been constituted members of the Special Committee on Prepaid Medical Care to study the whole subject and present its report to the regular session of the House in October, 1946. Such approval by the Medical Society of Milwaukee County to their designation on the special study committee consequently terminated with the discharge of that committee through acceptance of the report by the session of the House just ended. Con-

equently, these members did not have the endorse-ent of the Board of Directors of the Medical ociety of Milwaukee County. It was reported that he suggestion had been made that future members f the Operating Committee representing Milwaukee ounty be members of the Board of Directors of hat county society. It was said that no alternative emained to the three physicians from Milwaukee ounty in participating further in these delibera-ions unless endorsement by the Board of Directors as given. Consequently, it was suggested that a ommunication should be directed to the Board of irectors asking whom they would approve as the hree members representing the Medical Society of ilwaukee County.

It was then pointed out by the secretary that the ajority report, as accepted without amendment n that particular point, provided that the members f the special committee should continue as the mem-ers of the Operating Committee. There was no mendment offered by the delegation from Milwau-ee County relative to the approval of the three ilwaukee County members of the Operating Com-ittee.

It was suggested by the secretary that there was no subject properly before the Council upon which action could be taken.

Doctor Fons, a member of the committee, stated that the majority report, as accepted by the House of Delegates, provided limitation of terms for the members of the Operating Committee which had not been decided upon as yet.

It was pointed out that when there is provision for appointment of a committee and specific terms are to be assigned and the appointive power does not specifically designate terms, these may be determined by lot. It was suggested that this was a matter which the Operating Committee could well consider among themselves, and if some future problem should develop, it could be brought before the Council.

12. Adjournment

The Council adjourned at 3:50 p. m.

C. H. Crownhart
Secretary

Approved:
S. E. Gavin
Chairman of the Council

AMA AND NBC HONOR DOCTOR BEAUMONT

Doctor Beaumont extracting gastric juice from Alexis St. Martin.

"Doctors Then and Now" is the title of the radio series being presented this year by the AMA in cooperation with the National Broadcasting Company. As the title suggests the current series honors pioneer doctors drawn from various regions throughout the United States.

On Saturday, December 28, a dramatization of the life of Dr. William Beaumont who accomplished many of his experiments concerning the digestive system through study of "the man with the lid on his stomach" at Prairie du Chien, will be presented. The stations in this area which will broadcast the program are listed below. Dr. William A. O'Brien, director of postgraduate medical education and professor of public health at the University of Minnesota will present the picture of medicine as it is in this region today.

DOCTORS THEN AND NOW

Eau Claire	WEAU	3:00	p. m.	CST
La Crosse	WKBH	"	"	"
Madison	WIBA	6:30	p. m.	"
Marinette	WMAM	3:00	p. m.	"
Milwaukee	WTMJ	"	"	"
Minneapolis–St. Paul	KSTP	"	"	"
Chicago	WMAQ	"	"	"

Special Session, House of Delegates of The State Medical Society of Wisconsin

Held in Madison June 22, 1946, Speaker E. C. Cary, Presiding

The House of Delegates was called to order by Speaker Cary at 10:20 a. m. The report of the Credentials Committee, composed of Drs. T. C. Hemmingsen of Racine as chairman; G. W. Carlson, Appleton; and A. A. Cantwell, Shawano, was first called. Doctor Hemmingsen reported the registration of fifty members of the House and seven Councilors, and moved that the attendance record so compiled constitute the roll call of the session. This motion was seconded by Dr. G. W. Carlson of Appleton, put to a vote, and carried unanimously.

Speaker Cary then made the following statement: "This call for the special session was based upon petition of twenty-two delegates who submitted a resolution relative to the Surgical Care Plan of Milwaukee County. The call was expanded by formal action of the Council to include consideration of the report of the Committee on Veterans.

"As this is a special session, these matters are automatically introduced, and the resolution concerning Surgical Care is now referred to the Committee on Resolutions. The report of the Committee on Veterans is referred to the Reference Committee on Reports of Committees."

At this point Speaker Cary announced that a session of the Council had been held the previous evening, with the result that the Council had a special report to make to the delegates at this point in the procedure. Dr. S. E. Gavin, chairman of the Council, was recognized, and made the following report:

"Mr. Speaker, and members of the House of Delegates: by formal action of the Council these recommendations are presented to the Delegates:

"1. The proceedings of this special session be held in executive session, thus constituting the House its own press officer.

"2. It believes that both problems before the House are of very considerable interest and importance. It believes that every delegate should have the opportunity to attend reference committee sessions on those matters. It therefore suggests to the House that it instruct the reference committees to meet consecutively rather than concurrently, and to that end the first hearing be conducted by the Reference Committee on Resolutions, with the hearings on the veterans matter to follow."

Dr. C. M. Echols, Milwaukee, moved that the House proceed as a committee of the whole to hear discussions on the resolutions. Doctor Cary ruled the motion out of order, reminding delegates that the matter before the House was the report of the Council, as just submitted by its chairman. Dr. J. W. Fons, Milwaukee, raised the point that the motion presented by Doctor Echols was a privileged motion, but again Speaker Cary ruled that the business before the House was the report of the Council.

Dr. Norbert Enzer, Milwaukee, rose to discuss that portion of the report with respect to entering into executive session, and asked rejection.

Dr. S. O. Lund, Cumberland, moved that the recommendation of the Council with respect to going into executive session be rejected. The motion was seconded by Dr. J. W. Fons, Milwaukee, who rose to discuss the issue. The motion was then put to a vote and was carried.

Speaker Cary stated that the next question before the House was the recommendation of the Council pertaining to the reference committees meeting in consecutive rather than concurrent sessions. Doctor Echols then moved that the House go into committee of the whole to hear the discussions. Dr. J. S. Supernaw, Madison, rose to a point of parliamentary inquiry, asking if it were not true that there was a set procedure for reference committee consideration of the order of business. There was discussion by Doctor Enzer, following which it was moved and seconded that that portion of the recommendation of the Council be rejected. There was discussion by Dr. C. O. Vingom, Madison; Dr. Norbert Enzer, Milwaukee; Dr. J. W. Fons, Milwaukee; Dr. D. J. Twohig, Fond du Lac; and Dr. L. V. Littig, Madison. Speaker Cary stated the question. A roll call was demanded.

Dr. T. C. Hemmingsen, chairman, reported a supplementary report by the Credentials Committee, providing a total registration of fifty-nine delegates, and moved that the supplementary report be accepted, which motion was severally seconded and carried unanimously. There was further discussion by Drs. Dexter Witte, Milwaukee; C. O. Vingom, Madison; J. W. Fons, Milwaukee; and H. Kent Tenney, Madison. Upon request by Dr. Norbert Enzer Milwaukee, the recommendation of the Council was re-read.

The original motion, with consent of the second was withdrawn. Dr. J. S. Supernaw then moved adoption of the recommendation of the Council, seconded by Dr. G. H. Ewell, Madison. There was discussion by Dr. Dexter Witte, Milwaukee. The motion was then put to a vote, with the roll call as follows:

Delegate	*Yes*	*No*	*Not Voting*
S. O. Lund (Cumberland)	x		
O. W. Saunders (Green Bay)	x		
W. A. Killins (Green Bay)	x		
H. H. Christofferson (Colby)	x		
E. F. Tierney (Portage)	x		
G. R. Hammes (Seneca)	x		
J. S. Supernaw (Madison)	x		

Delegate	*Yes*	*No*	*Not Voting*
R. F. Schoenbeck (Stoughton)	x		
C. G. Reznichek (Madison)	x		
G. H. Ewell (Madison)	x		
H. Kent Tenney (Madison)	x		
F. G. Bachhuber (Mayville)	x		
Milton Finn (Superior)	x		
W. R. Manz (Eau Claire)	x		
D. J. Twohig, Sr. (Fond du Lac)	x		
O. S. Tenley (Wabeno)	x		
E. C. Howell (Fennimore)			x
M. W. Stuessy (Brodhead)	x		
L. J. Seward (Berlin)	x		
S. B. Marshall (Hollandale)	x		
G. E. Eck (Lake Mills)	x		
C. A. Vogel (Elroy)	x		
W. C. Stewart (Kenosha)	x		
J. C. Fox (La Crosse)	x		
L. A. Van Ells (Shullsburg)	x		
R. G. Baker (Tomahawk)	x		
E. C. Cary (Reedsville)	x		
H. H. Christensen (Wausau)	x		
J. M. Bell (Peshtigo)		x	
S. A. Morton (Milwaukee)		x	
M. J. Bach (Milwaukee)		x	
L. H. Guerin (Milwaukee)		x	
T. J. Aylward (Milwaukee)		x	
W. A. Ryan (Milwaukee)		x	
Forrester Raine (Milwaukee)		x	
N. W. Bourne (Milwaukee)		x	
C. M. Echols (Milwaukee)		x	
Norbert Enzer (Milwaukee)		x	
R. F. Purtell (Milwaukee)		x	
J. W. Fons (Milwaukee)		x	
F. A. Ross (Milwaukee)		x	
J. S. Allen (Norwalk)	x		
W. S. Bump (Rhinelander)	x		
G. W. Carlson (Appleton)	x		
O. H. Epley (New Richmond)	x		
L. O. Simenstad (Osceola)	x		
R. W. Rice (Stevens Point)	x		
J. D. Leahy (Park Falls)	x		
T. C. Hemmingsen (Racine)		x	
H. E. Kasten (Beloit)	x		
Roger Cahoon (Baraboo)	x		
A. A. Cantwell (Shawano)		x	
C. J. Weber (Sheboygan)	x		
R. L. MacCornack (Whitehall)	x		
R. S. Hirsch (Viroqua)	x		
E. D. Sorenson (Elkhorn)	x		
J. G. Hoffmann (Hartford)	x		
H. T. Barnes (Delafield)		x	
G. R. Anderson (Neenah)		x	
K. H. Doege (Marshfield)	x		
A. H. Pember (Janesville)	x		
R. P. Montgomery (Milwaukee)		x	
L. V. Littig (Madison)	x		

Dr. S. A. Morton, Milwaukee, rose to the point of order that some Milwaukee names were not called. The secretary stated that the roll call was based upon the names filed with the secretary by the Committee on Credentials, reporting fifty-nine accredited delegates. Dr. J. V. Herzog, Milwaukee, stated that he was a properly accredited alternate and was entitled to vote. Dr. J. J. Gramling, Jr., stated that he was a properly accredited alternate and, with the delegate not in the House, he had the privilege of voting. The secretary noted that Dr. H. E. Kasten of Beloit and Dr. J. C. Fox of La Crosse had registered since the last report of the Committee on Credentials.

Dr. Forrester Raine, Milwaukee, raised the point of the necessity of alternate delegates being alternate for a specific regular delegate. Speaker Cary stated that he would entertain a motion that Milwaukee be allowed seventeen votes. Dr. H. Kent Tenney so moved, and Doctor Hemmingsen seconded. The motion was put to a vote and carried.

The secretary then raised the question of the House as to whether to permit Dr. O. W. Saunders of Brown–Kewaunee–Door County Medical Society to be entitled to a vote, inasmuch as he was present, but the delegate for whom he served as alternate was also present. The secretary stated that the other delegate and alternate delegate were absent. On motion of Dr. Norbert Enzer, variously seconded, these two members were accredited as the official representatives of the Brown–Kewaunee–Door County Medical Society.

On motion of Dr. H. H. Christofferson, Colby, variously seconded, Dr. J. C. Fox of La Crosse, Dr. H. E. Kasten of Beloit, and Dr. Roger Cahoon of Baraboo were accepted as accredited delegates. The recorded vote was then read, with the result being 44 "aye," 23 "no," and 1 not voting.

Speaker Cary announced reference committee appointments as follows:

Committee on Reports of Officers

A. M. Christofferson, Waupaca, chairman
W. A. Ryan, Milwaukee
S. E. Williams, Chippewa Falls
L. M. Lundmark, Ladysmith

Committee on Reports of Committees

D. J. Twohig, Fond du Lac, chairman
Arnold Barr, Port Washington
H. E. Kasten, Beloit
C. M. Echols, Milwaukee

Committee on Resolutions and Amendments to the Constitution and By-Laws

K. H. Doege, Marshfield, Chairman
L. O. Simenstad, Osceola
E. D. Sorenson, Elkhorn
J. S. Supernaw, Madison
R. P. Montgomery, Milwaukee

Subsequently the Speaker asked for further resolutions and recognized Dr. H. Kent Tenney of Madison, who addressed the House as follows:

Mr. Speaker and fellow delegates: In the consideration of the problems raised with reference to prepaid medical care plans by reason of this special session of the House, we believe that there are certain fundamental matters which should control the ultimate decision to be made at this time.

We believe it important to keep in mind that the profession of this state has endorsed the principle of prepaid medical care insurance, as has the profession nationally. Such debate as now exists here is not a debate as to the advisability of such an undertaking, but the mechanics for its management and sale. Wisconsin has endorsed a plan now being carried out by licensed insurance carriers. At least two other states are following similar procedure, and in several other states the medical profession has

organized an insurance company for the writing of this type of risk.

Even before this plan was inaugurated there was instituted in Milwaukee County a prepaid plan similar to those being conducted in California, Michigan and elsewhere. It is significant to us that the Council of the State Medical Society initially authorized the conduct of this effort experimentally, and has appropriated funds to assist in its administration during its formative period.

We believe that this is not the time for accusations or recriminations with reference to the difficulties that have since arisen. We propose not to discuss the problem in that aspect, but to discuss the problem now before the House which is whether there shall be, in addition to the Wisconsin Plan, a second state-wide plan utilizing a different means to the same end and having the endorsement of the profession. On the basis of its experience to this date, the Medical Society of Milwaukee County believes this feasible.

We, of an area not a part of Milwaukee County, accept that Society's position that the development of a state-wide plan of the character of Surgical Care will serve further the declared purpose of our profession in fostering prepaid medical care insurance.

However, any plan to be truly state-wide requires management derived from the state as a whole. We possess no voice in the functions of the Medical Society of Milwaukee County, and neither do the members of that Society possess a voice in the affairs of other county societies; but each county society has a voice in the State Medical Society of Wisconsin. Were any other policy in effect, the counties which we represent might well inaugurate a plan similar to that in Milwaukee County, and engage in efforts to sell it not only within our counties but others as well. It is obvious that such a program could not serve effectively the best interest of the public.

In view of the belief of the Milwaukee Society that Surgical Care should be expanded outside of Milwaukee County, we favor action by this House of Delegates to establish on a state-wide basis, and through our State Society, a plan of prepaid medical care insurance of the character of Surgical Care of Milwaukee County. We also favor this House going on record in appreciation of the devoted and arduous labors of the Medical Society of Milwaukee County in the field of experimental prepaid medical insurance.

In view of this experience we seek its cooperation in developing this state-wide program which, as soon as possible, would absorb Surgical Care of Milwaukee County, thus fulfilling the statement of two years' standing of Milwaukee County representatives that at such time as the State Medical Society developed a state-wide program of this character, the local Society would replace Surgical Care within its framework.

There remains but one further question, and that is the attitude of our State Society toward Associated Hospital Service, Inc., commonly known as Blue Cross.

Six years ago this Society officially declared its divorcement from that organization on the basis that it incorporated, among other things, the sale of medical service within the general definition of hospital services, in face of a contrary provision in its enabling act. We know that both Blue Cross and agencies of this Society have made efforts in the intervening period to reconcile those differences. We believe that with the development of a state-wide program of the character proposed by us, the leadership of both organizations will have a way opened to such a solution at this time. We believe that our common objectives will surmount in importance any obstacles that now remain. We believe this can be done for the future welfare of the patient, the hospital and the physician.

We offer with this statement a resolution to carry out the proposal we make.

Resolved:

"1. That the House of Delegates authorize the Council of the State Medical Society to establish a state-wide prepaid medical care organization of the character of Surgical Care, and to absorb Surgical Care of Milwaukee County at the earliest feasible moment.

"2. That the organization be representative so nearly as may be practical of the geographic areas of the state and their physician population.

"3. That the plan be so devised as to permit it to be sold in conjunction with the Blue Cross plan of hospitalization, and to that end the Council be directed to engage in an immediate effort to eliminate present difficulties with that organization.

"4. That this House of Delegates approve the 'manner of establishment' of the Surgical Care plan in Milwaukee County as shown by the official action of the State Medical Society.

"5. That this House of Delegates urge the wholehearted cooperation of all physicians with the Plan authorized under this resolution, as well as their continued cooperation with the Wisconsin Plan."

May I make one more statement: In our deliberations over this whole problem may we please keep our attention riveted on the aspects in which we are in perfect agreement, with the sure knowledge then that our disagreements will almost automatically resolve themselves. Make no mistake about it, the deliberations of this body will have reverberations far beyond our state borders. Those who are planning social legislation would like nothing better than to see this session end up in a lot of bickering. If we will keep our eyes on the future, on the fact that we do agree in most things, then organized medicine as represented by the State Medical Society of Wisconsin will take another step down the long road of medical progress.

There was discussion by Dr. C. M. Echols, Milwaukee, who then moved that all resolutions pertaining to Surgical Care be withdrawn from the Resolutions Committee and be heard before the House sitting as a committee of the whole. This motion was seconded by Dr. F. E. Drew, Milwaukee. Speaker Cary announced this motion operated to suspend the rules and a two-thirds vote was required. There was further discussion. A roll call vote was demanded.

Dr. T. C. Hemmingsen, Racine, chairman of the Credentials Committee, reported further registration, making a total of sixty-three delegates entitled to vote.

The secretary called the roll polling the seventeen votes of Milwaukee County as a bloc voting pursuant to earlier motion.

Dr. W. A. Ryan of Milwaukee objected to the acceptance of bloc voting from Milwaukee County. Dr. Norbert Enzer stated that Milwaukee County would present the names as they voted at a later date.

Dr. L. W. Hipke of Milwaukee asked the privilege of the floor. Speaker Cary asked for a determination of the vote, and the secretary announced that 68 delegates had voted, 42 "aye" and 26 "no." Speaker

Cary announced that the required number of votes to carry was 46, and the motion lost. Doctor Ryan then asked the secretary to explain the Milwaukee County vote. The Speaker announced that the executive secretary of the Medical Society of Milwaukee County had later delivered the roll call of the Milwaukee delegation to the Speaker's desk, and announced that the vote had been taken and stands. He then called for any further resolutions.

Dr. Norbert Enzer offered the following amendment to the resolution which had served for the purpose of the call:

Resolved: That the resolution heretofore submitted by the Medical Society of Milwaukee County be amended to read as follows:

"1. That the House of Delegates of the State Medical Society of Wisconsin does hereby approve the manner of establishment of the Surgical Care plan established and operated by the Medical Society of Milwaukee County, providing always that such approval places no financial obligation nor liability on the State Medical Society of Wisconsin.

"2. That the Surgical Care service plan shall be made available to the entire State of Wisconsin, and that a committee of six be appointed, three of whom shall be appointed by this House of Delegates, and three by the Board of Directors of the Medical Society of Milwaukee County; that the purpose of this committee shall be to study and develop detailed plans for the establishment of Surgical Care as a state-wide organization, and to present such plan of operation to the House of Delegates at their next annual session.

"3. That the Associated Hospital Services, Inc., be authorized as a selling, billing, and enrolling agency for Surgical Care to the people of Wisconsin until such time as the final plans are established; that the divorcement actions of the House of Delegates with respect to the separation of interests between the State Medical Society of Wisconsin and the Associated Hospital Services, Inc. (Blue Cross), be revoked.

"4. That the House of Delegates urges the wholehearted support and cooperation of the membership of the State Medical Society of Wisconsin for the sale and operation of Surgical Care in the State of Wisconsin."

Doctor Enzer then moved adoption of the amendment. Seconded by Dr. F. A. Ross, Milwaukee, the motion was put to a vote and carried.

Dr. F. E. Drew, Milwaukee, renewed the motion that the House of Delegates consider the matter as a committee of the whole. The Vice-Speaker, Dr. L. O. Simenstad of Osceola, assumed the chair. The motion by Doctor Drew was seconded by Dr. C. M. Echols. Discussion was called for. There was discussion by Drs. C. O. Vingom, Madison; Dexter Witte, Milwaukee; D. J. Twohig, Fond du Lac; and H. E. Kasten, Beloit.

The question was called for. The motion was put to a vote and lost. Speaker Cary resumed the chair.

The Speaker called on the secretary for announcements, who then summarized activities with reference to the Wagner–Murray–Dingell legislation, and transmitted the request of Dr. James C. Sargent, Milwaukee, who the previous day had appeared in Washington against the Wagner–Murray–Dingell bill, for an opportunity to address the House.

On motion by Dr. H. H. Christofferson, variously seconded, the House recessed until 7 o'clock.

Reconvened Session of the House

The House was reconvened at 7:20 p. m., June 22, 1946, Speaker Cary presiding. Dr. James C. Sargent was recognized. He summarized the problems in connection with various legislation and the situation he had encountered in appearing as a representative of the State Medical Society in opposition to the bill. He asked acceptance and vote upon a resolution under suspension of the rules as follows:

WHEREAS, in the hearings on S, 1606 (which is the Wagner–Murray–Dingell bill) it becomes evident that a concerted effort is being made by its proponents to create the impression that the medical profession of the country is seriously divided on the issues involved, through the use of numerous individual physicians and the small groups of physicians who are admitted to appear in favor of the bill; be it

Resolved: That this House of Delegates of the State Medical Society of Wisconsin, sitting in special session at Madison, the 22nd day of June, 1946, representing as it does the 2,700 physicians throughout the State of Wisconsin, record its considered judgment that proposed legislation such as that of S. 1606, if ever enacted, would seriously jeopardize the proper and adequate care of the sick people of America; and be it further

Resolved: That a copy of this resolution, together with a true record of the "aye" and "nay" votes, be forwarded to the Honorable J. E. Murray with the request that it be incorporated in the records of the hearing of the Committee on Education and Labor, and that a second copy be sent to the Honorable Robert M. La Follette, senior senator from Wisconsin and member of that committee; and be it further

Resolved: That the Wisconsin Delegates representing the State Society in the American Medical Association be instructed to introduce a resolution of similar intent and wording at the July 1946 session of the House of Delegates.

Vice-Speaker Simenstad assumed the chair. Dr. C. J. Weber of Sheboygan moved adoption of the resolution as contained in Doctor Sargent's suggestion. The motion was seconded by Dr. R. L. MacCornack, Whitehall, put to a vote, and carried unanimously.

Vice-Speaker Simenstad called on the chairman of the Reference Committee, Dr. D. J. Twohig, to report on the report of the Committee on Veterans. Doctor Twohig, as chairman of the Reference Committee, moved adoption of the following resolution:

Resolved: That the House of Delegates of the State Medical Society of Wisconsin, on the authority of its Constitution and By-Laws, and also on the authority contained in Chapter 148, Wisconsin Statutes, create the Veterans Medical Service Agency as an official agency of this Society.

Such agency shall be under the general direction of the Society, and its membership shall be geographically representative of the profession in the state. The agency shall be organized and developed by the Council.

This agency will be empowered to contract with the Veterans Administration for the physical examination, treatment and medical care of veterans, and

with state and other agencies authorized by law to administer the various medical and other programs designed for veterans.

This agency shall be further empowered to contract with physicians and others in carrying out the functions assigned it, to provide for administrative procedures necessary thereto, and, on behalf of the Society and subject to direction of the Council and the House of Delegates, to conduct all such business of said agency.

This motion was seconded by Dr. G. W. Carlson, Appleton. This motion was put to a vote and carried unanimously.

Speaker Cary resumed the chair and called on Dr. Karl H. Doege, chairman of the Reference Committee on Resolutions, to report on behalf of that committee, which report was made as follows:

In view of the belief of the Milwaukee Society that Surgical Care should be expanded outside of Milwaukee County, we favor action by this House of Delegates to establish on a state-wide basis, and through our State Society, a plan of prepaid medical care insurance of the character of Surgical Care of Milwaukee County.

We also favor this House going on record in appreciation of the devoted and arduous labors of the Medical Society of Milwaukee County in the field of experimental prepaid medical insurance. In view of this experience we seek its cooperation in developing this state-wide program which would, as soon as is possible, absorb Surgical Care of Milwaukee County.

We therefore offer the following resolution:

Resolved:

"1. That the House of Delegates create a committee to arrange the establishment of a state-wide prepaid medical care organization of the character of Surgical Care, this committee to arrange for the absorption of Surgical Care of Milwaukee County at the earliest feasible time, the proposed plan to be mailed to the Delegates and Alternate Delegates not less than ten days prior to the next annual session of the House.

"2. That this committee shall be composed of nine members to be appointed by the Speaker of the House, three members from recommendations from the delegation of Milwaukee County, one from Racine and Kenosha Counties, and five from the state at large outside of Milwaukee, Racine and Kenosha Counties, all appointments to be ratified by the House of Delegates.

"3. That the plan be so devised as to permit it to be sold in conjunction with the Blue Cross plan of hospitalization, and to that end the committee be directed to engage in an immediate effort to eliminate present difficulties with that organization.

"4. That this House of Delegates approve the 'manner of establishment' of the Surgical Care plan in Milwaukee County as shown by the official action of the State Medical Society.

"5. That this House of Delegates urge the wholehearted cooperation and support of all physicians with the plan authorized under this resolution, as well as their continued cooperation with the Wisconsin Plan."

K. H. Doege
J. S. Supernaw
E. D. Sorenson
L. O. Simenstad
R. P. Montgomery

Chairman Doege moved adoption of the resolution. The motion was seconded by Dr. C. M. Echols, Milwaukee.

Dr. W. A. Ryan, Milwaukee, moved a ten-minute recess. Dr. R. L. MacCornack seconded. The motion was put to a vote and lost.

Doctor Purtell asked the House to consider an amendment, the effect of which was to give immediate approval to the Blue Cross effort, asking that it be an amendment to the second sentence of paragraph number 3, and requesting that it read:

"The plan be so devised as to permit it to be sold in conjunction with the Blue Cross plan of hospitalization, and to that end the House of Delegates revoke its divorcement proceedings and give unqualified approval of Blue Cross."

Doctor Purtell so moved. Dr. D. J. Twohig seconded the motion.

Dr. Norbert Enzer, Milwaukee, was recognized, and stated that he believed that the words "and through our State Society" in the preamble be deleted. In the fourth line he asked that the word "insurance" be deleted.

In the second part of the resolution he requested that the Board of Directors of the Medical Society of Milwaukee County name the three members representing the Milwaukee division on the committee.

He asked that the words "as shown by the official action of the State Medical Society" be stricken. He noted omission in the resolution with reference to the sale, billing, and joint operation of Surgical Care through Blue Cross.

Dr. R. S. Hirsch, Viroqua, called attention of the House that there was a motion by Doctor Purtell, and asked Doctor Purtell to permit deletion from paragraph 3 of the balance of the paragraph following the first semicolon, making that a separate resolution. This suggestion being accepted, Speaker Cary announced that the proposed amendment then read "that the plan be so devised as to permit it to be sold in conjunction with the Blue Cross plan of hospitalization."

The amendment as stated was carried, but not unanimously.

Doctor Enzer asked to amend the report in accordance with the remarks he had just made. Speaker Cary asked him to restate them.

Doctor Enzer then moved that the phrase "and through our State Society" be stricken. This motion was seconded by Dr. M. Q. Howard, Milwaukee. There was discussion by Drs. C. O. Vingom, Madison; H. Kent Tenney, Madison; and C. J. Weber, Sheboygan. The motion was lost.

Doctor Enzer moved that the word "insurance" be stricken from the fourth line of the first paragraph. This motion was seconded by Dr. N. W. Bourne, Milwaukee. The motion was put to a vote and carried, but not unanimously.

Doctor Enzer moved that clause 2 be amended to read as follows:

"This committee shall be composed of nine members of the Medical Society, three members appointed by the Board of Directors of the County Society of Milwaukee County."

Dr. G. W. Carlson seconded the motion. There was discussion by Doctors Vingom, Enzer, Hipke, and by

Speaker Cary. The amendment was withdrawn, with the consent of the second.

Doctor Enzer moved that the phrase "as shown by the official action of the State Medical Society" be stricken, and that the phrase "Surgical Care plan in Milwaukee County" be changed to "the Surgical Care plan of Milwaukee County." The motion was seconded by Doctor Purtell. There was discussion by Doctors Hipke; Enzer; Dexter Witte; C. A. Dawson, president-elect of the Society; J. S. Supernaw, Madison; and P. R. Minahan, Green Bay. Speaker Cary put the motion to a vote, and it was carried, but not unanimously.

Dr. W. A. Ryan then moved for a ten-minute recess. The motion was severally seconded, was put to a vote, and was carried.

The House was reconvened, and Dr. R. G. Arveson, Frederic, councilor, was recognized. He offered the suggestion that paragraph number 3 should be worded as follows: "The plan be so devised as to permit it to be sold in conjunction with the Blue Cross plan of hospitalization, that the divorcement action of the House of Delegates in 1940 with respect to separation of the State Medical Society and the Associated Hospital Service, Inc. be rescinded." The motion, variously seconded, was put to a vote and carried.

Speaker Cary announced that the question before the House was for a vote on the report as a whole as amended. A motion was made to that effect and was carried unanimously.

Dr. S. A. Morton, Milwaukee, expressed the appreciation of the delegates from Milwaukee County, and the House gave the Milwaukee County Medical Society a rising vote of thanks.

Speaker Cary announced appointments to the special committee just authorized, as follows:

Dr. Dexter H. Witte, Milwaukee
Dr. J. W. Fons, Milwaukee
Dr. J. W. Truitt, Milwaukee
Dr. W. C. Stewart, Kenosha
Dr. E. M. Dessloch, Prairie du Chien
Dr. L. V. Littig, Madison
Dr. A. T. Nadeau, Marinette
Dr. Gunnar Gundersen, La Crosse
Dr. C. O. Vingom, Madison

On motion of Dr. R. G. Baker, Tomahawk, seconded by Doctor Wilkinson of Oconomowoc, the motion to approve these appointments was put to a vote and carried.

The meeting adjourned sine die at 9 o'clock.

Attendance at House of Delegates, Madison, June 1946

Society	*Delegate*	
Ashland–Bayfield–Iron	C. W. Lockhart, Mellen	a
	W. E. Bargholtz, Ashland*	a
Barron–Washburn–Sawyer–Burnett	S. O. Lund, Cumberland	x
	O. E. Rydell, Rice Lake*	a
Brown–Kewaunee–Door	O. W. Saunders, Green Bay	x
	W. A. Killins, Green Bay*	x
	A. J. McCarey, Green Bay	a
	W. P. Tippet, Green Bay*	a
Calumet	A. C. Engel, New Holstein	x
	N. J. Knauf, Chilton*	a
Chippewa	S. E. Williams, Chippewa Falls	a
	Frank Sazama, Chippewa Falls*	a
Clark	H. H. Christofferson, Colby	x
Columbia–Marquette–Adams	E. F. Tierney, Portage	x
	R. B. Dryer, Poynette*	x
Crawford	G. R. Hammes, Seneca	x
	E. H. Lechtenberg, Prairie du Chien*	a
Dane	J. S. Supernaw, Madison	x
	A. C. Stehr, Madison*	a
	R. F. Schoenbeck, Stoughton	x
	F. F. Bowman, Madison*	a
	N. A. Hill, Madison	a
	C. G. Reznichek, Madison*	x
	G. H. Ewell, Madison	x
	Gorton Ritchie, Madison*	a
	H. Kent Tenney, Madison	x
	L. R. Cole, Madison*	x
Dodge	F. G. Bachhuber, Mayville	x
	E. S. Elliott, Fox Lake*	x
Douglas	J. W. McGill, Superior	a
	Milton Finn, Superior*	x
	H. A. Sincock, Superior*	a
Eau Claire–Dunn–Pepin	W. R. Manz, Eau Claire	x
	B. F. Johnson, Mondovi*	a
Fond du Lac	D. J. Twohig, Sr., Fond du Lac	x
	D. N. Walters, Fond du Lac*	x
Forest	O. S. Tenley, Wabeno	x
	G. W. Ison, Crandon*	a
Grant	E. C. Howell, Fennimore	x
	J. D. Glynn, Lancaster*	a
Green	M. W. Stuessy, Brodhead	x
	F. J. Bongiorno, Albany*	a
Green Lake–Waushara	L. J. Seward, Berlin	x
	S. L. Hadden, Wild Rose*	a
Iowa	S. B. Marshall, Hollandale	x
	H. M. Walker, Dodgeville*	x
Jefferson	G. E. Eck, Lake Mills	x
	O. F. Dierker, Watertown*	a
Juneau	C. A. Vogel, Elroy	x
	J. S. Hess, Mauston*	a

* After name—alternate delegate. x Present. a Absent.

Society	*Delegate*	
Kenosha	W. C. Stewart, Kenosha	x
	A. F. Ruffilo, Kenosha*	a
La Crosse	J. C. Fox, La Crosse	x
Lafayette	H. F. Hoesley, Shullsburg	a
	L. A. Van Ells, Shullsburg*	x
Langlade	C. E. Zellmer, Antigo	a
	W. P. Curran, Antigo*	a
Lincoln	R. G. Baker, Tomahawk	x
	K. A. Morris, Merrill*	a
Manitowoc	E. C. Cary, Reedsville	x
	T. H. Rees, Manitowoc*	a
Marathon	E. E. Fleming, Wausau	a
	H. H. Christiansen, Wausau*	x
Marinette–Florence	J. M. Bell, Peshtigo	x
	J. D. Zeratsky, Marinette*	x
Milwaukee	E. D. Schwade	x
	J. R. Regan*	a
	S. A. Morton	x
	H. J. Gramling*	x
	M. J. Fox	a
	E. L. Bernhart*	a
	M. J. Bach	x
	D. J. Ansfield*	a
	Aaron Yaffe	a
	L. H. Guerin*	x
	T. J. Aylward	x
	O. A. Sander	x
	Joseph Lettenberger*	a
	J. J. Gramling, Jr.	x
	C. F. McDonald*	a
	W. A. Ryan	x
	A. D. Spooner*	x
	Forrester Raine	x
	W. J. MacKedon*	a
	F. E. Drew	x
	N. W. Bourne*	x
	C. M. Echols	x
	M. W. Sherwood*	x
	Norbert Enzer	x
	J. V. Herzog*	x
	R. F. Purtell	x
	M. Q. Howard*	x
	J. W. Fons	x
	W. J. Houghton*	a
	J. W. Truitt	a
	A. I. Rosenberger*	a
	F. A. Ross	x
	J. D. Steele*	x
Monroe	A. E. Winters, Tomah	a
	J. S. Allen, Norwalk*	x
Oconto	R. J. Goggins, Oconto Falls	a
	A. F. Slaney, Oconto	a
Oneida–Vilas	W. S. Bump, Rhinelander	x
	I. E. Schiek, Rhinelander*	a
Outagamie	G. W. Carlson, Appleton	x
	J. L. Benton, Appleton*	a
Pierce–St. Croix	C. E. McJilton, River Falls	a
	O. H. Eoley, New Richmond*	x
Polk	L. O. Simenstad, Osceola	x
	V. C. Kremser, Amery*	a
Portage	R. W. Rice, Stevens Point	x
	W. C. Sheehan, Stevens Point*	a
Price–Taylor	J. D. Leahy, Park Falls	x
	L. E. Nystrum, Medford*	a
Racine	T. C. Hemmingsen, Racine	x
	E. J. Schneller, Racine*	a
Richland	Geo. Parke, Sr., Viola	a
	D. J. Taft, Richland Center*	a
Rock	H. E. Kasten, Beloit	x
	W. T. Clark, Janesville*	a
Rusk	L. M. Lundmark, Ladysmith	a
	Woodruff Smith, Ladysmith*	a
Sauk	Roger Cahoon, Baraboo	x
	J. F. Moon, Baraboo*	a
Shawano	A. A. Cantwell, Shawano	x
	E. E. McCandless, Birnamwood*	a
Sheboygan	C. J. Weber, Sheboygan	x
	P. B. Mason, Sheboygan*	x
Trempealeau–Jackson–Buffalo	R. L. MacCornack, Whitehall	x
	Robert Krohn, Black River Falls*	x
Vernon	R. S. Hirsch, Viroqua	x
	F. F. Gollin, LaFarge*	a
Walworth	E. D. Sorenson, Elkhorn	x
	R. A. Mullen, Burlington*	a
Washington–Ozaukee	Arnold Barr, Port Washington	x
	J. G. Hoffmann, Hartford*	x
Waukesha	H. T. Barnes, Delafield	x
	E. C. Van Valin, Sussex*	x
Waupaca	A. M. Christofferson, Waupaca	a
	F. J. Pfeifer, New London*	a
Winnebago	G. R. Anderson, Neenah	x
	W. A. Wagner, Oshkosh*	a
Wood	K. H. Doege, Marshfield	x
	F. X. Pomainville, Wis. Rapids*	a
Section on Cardiology	A. W. Bryan, Madison	a
	F. D. Murphy, Milwaukee*	a
Section on Ophthalmology and Otolaryngology	J. K. Trumbo, Wausau	a
	A. H. Pember, Janesville*	x
Section on Orthopedics	R. P. Montgomery, Milwaukee	x
	L. D. Smith, Milwaukee*	a
Section on Radiology	L. V. Littig, Madison	x
	R. F. Wilson, Beloit*	x

Transactions 1946 Regular Sessions, House of Delegates, State Medical Society of Wisconsin

Sunday Session

The opening session of the House of Delegates of the State Medical Society of Wisconsin was called to order by Speaker E. C. Cary, Reedsville, at 5:00 p. m., Sunday, October 6, 1946.

The Speaker announced the appointments to the Committee on Credentials with Drs. T. C. Hemmingsen, Racine, chairman; G. W. Carlson, Appleton; and A. A. Cantwell, Shawano. In behalf of the committee, Doctor Hemmingsen reported the registration of fifty delegates and five alternate delegates entitled to vote at this session of the House. Upon his motion, seconded by Dr. H. T. Barnes, Delafield, the report of the Committee on Credentials was accepted.

Speaker Cary then reminded delegates present that the House of Delegates constitutes the democratic organization for the expression of views within the State Medical Society and that each member of the House should feel free to express his opinion at any time.

The Speaker noted that the entire proceedings of the 1945 regular session were printed as a supplement to the December 1945 issue, of The Wisconsin Medical Journal, and upon motion of Dr. C. M. Echols, Milwaukee, seconded by Dr. D. J. Twohig, Fond du Lac, these were accepted as the minutes of the House for that year.

Adoption of Standing Rules

Speaker Cary presented the standing rules of previous sessions, as follows:

1. Without permission of the House, reports of officers be limited to twenty minutes.

2. Without permission of the House, supplementary reports of committee chairmen or members be limited to five minutes.

3. Rule 7, Roberts Rules of Order, be modified by the proviso that no member can speak longer than five minutes at a time in debate without permission of the House.

4. The Committee on Nominations shall remain in open session for one hour to hear any member of the Society who may have suggestions, after which it may proceed in closed session.

On motion of Dr. O. A. Sander, Milwaukee, seconded by Dr. Charles Fidler, Milwaukee, the standing rules were adopted unanimously for this session.

Supplementary Reports

Dr. S. E. Gavin, Fond du Lac, presented a supplementary report on behalf of the Council of the State Medical Society. He directed attention of the House to the fact that at the request of the American Medical Association, the Council had authorized the appointment of a Committee on Military Medical Service, composed of four ex-service men and three others. Composition of the committee consisted of Drs. W. A. Ryan, Milwaukee, chairman; R. B. Dryer, Poynette; J. L. Moffett, Platteville; J. S. Wier, Fond du Lac; K. G. Pinegar, Marinette; Milton Finn, Superior; and C. Y. Wiswell, Williams Bay.

In addition, the supplementary report noted the appointment of the Committee on Fee Schedules, authorized to study the various fee schedules now in utilization by the various governmental agencies in Wisconsin as well as in the United States. Doctor Gavin reported that at the session of the Council preceding this session of the House life membership had been conferred upon Dr. Alfred E. Belitz of Pepin, and that, by Council action, the following matters were referred to the House of Delegates for consideration:

1. The recommendation of the American Medical Association urging the establishment of a Section on General Practice of Medicine.

2. A resolution submitted by Doctor Beebe, councilor from Sparta, urging the American Medical Association to continue the activities of its Council on Medical Education and Hospitals.

3. A resolution submitted by the Committee on School Health, asking the profession to be on record in opposition to the contemplated expansion of interscholastic athletic competition below the senior high school level.

4. A communication from the American Medical Association, asking that the State Medical Society be placed on record urging complete population coverage with modern public health organizations on a county, joint county, or district basis.

Report by President P. R. Minahan

This year marks the 105th anniversary of the organization of the State Medical Society of Wisconsin. It also marks the 170th year of American independence. Incidentally, it finds us in the midst of world turmoil wherein the clashing of ideologies is depriving us of the peace and comfort that our knowledge and ingenuities entitle us to have.

Medicine is not isolated and free from the troubled consequences of these intemperate times, and perhaps some of our distresses may originate within our own ranks wherein exist some of the centrifugal mental immoderations that appear to be the habit of the hour.

For a year I have had the honor of being the president of this Society, and it is now my duty to give you a brief report of the official activities of

the time I have served you, with such observations that may be proper and helpful in the effort to keep the continuity of service by this body unimpaired.

It can be truly stated—and no disclaimer can erase the living facts—that however medicine is affected issues from a world conflict of ideas wherein the older orders of life are opposed to the aggressive front of totalitarian, revolutionary force. Nor should it be concealed that the subjection of medical services to socialistic programs cannot be accomplished without reducing our whole order to the totalitarian scheme.

Without assuming to discuss the charges against medicine that range from the mistaken to the willfully fallacious, it is obligatory upon your officers to inform you of the measures that have been initiated or continued to preserve this great professional institution, that it may not be hampered or destroyed in its mission of preserving and restoring health and its contingent happiness to mankind.

These measures that have been taken are a natural corollary to the conditions indicated, and should be continued regardless of any sacrifices involved. Whatever time we may devote to these efforts detracts from scientific study and investigation, a circumstance that is sincerely regretted. Certainly there will be no pecuniary loss to the profession; but there will be material benefit to the public if we can aid in easing the peculiar difficulties of the times.

It is true that inadequacies are sometimes apparent in medical service; but inadequacies are found in every work and feature of our complicated existence. The inadequacies of government have perplexed thinkers in all the ages, and are still distressingly present. Food, clothing, housing, employment, and transportation have been and are inadequate. There is no major human effort that is fully and satisfyingly efficient. However, we can honestly ask for a comparison of medical service with other activities, fully confident that we are nearer to the goal of attainment than are they.

There have been increased costs in providing medical service, somewhat comparable with the increased costs of the necessities and luxuries of life. This condition of high costs imposes a hardship upon people of low incomes, particularly when the demands come with catastrophic suddenness. There is only one remedy that we have against catastrophe, and I am not referring to indigent problems; that is insurance, which distributes the costs of disaster. Medicine contends that insurance should be voluntary as to the individual in keeping with his dignity as a citizen.

The proponents of the socialistic scheme urge compulsory insurance by government, with the premiums extracted from the paycheck of the worker, and taxed against the employer and others. The profession of Wisconsin has presented plans for carrying out the voluntary insurance principle in matters of health. One is an indemnity plan of insurance; the other is a service plan. Only experience will tell whether one or both plans will survive. One or both must survive if medical practice as we know it is to survive. Therefore, the physicians have but one recourse—to support the work of our Society earnestly and fully against those who quibble, misdirect, or misinform, God only knows from what mistaken or ulterior motives.

The State Medical Society has been working diligently with the Veterans Bureau formulating a program for the care of veterans for disabilities that are service-connected. These conferences are progressing rapidly toward a fair arrangement for the veteran and physician. It is a shining commentary on the strength, fairness, and integrity of medical societies when a government bureau recognizes their ability to handle medical service more efficiently than a government agency.

Continuing its established policy of promoting measures in the interest of public health, the State Medical Society has cooperated with the State Board of Health and other agencies active in that field. It has acted to extend the scope of humanitarian legislation by appealing to legislative bodies to improve present hospitals and facilities for the care of the helpless and the unfortunate.

In conjunction with the county judges of the state, it is urging that all physically and mentally helpless be covered by appropriate legislation, leaving none, senile, paralytic or cancerous, out of their program for efficient care. We ask the cooperation of all physicians, nurses, and members of the Auxiliary to support these humanitarian measures.

In this connection it is proper, also, to call the attention of hospitals, physicians, and nurses to the necessity of reviewing the rules relative to nursing education, that there be no dearth of nursing personnel in our homes and hospitals. This is an important and timely matter. Its solution in the public interest will aid materially in conserving to us, the hospitals and nurses, the dignity and independence of our professions.

The State Medical Society of Wisconsin has aided materially in the dissemination of public and private health information through the instrumentalities of press and radio. We have had valuable and willing cooperation from these news agencies, and the public response has demonstrated a widespread, growing demand for a continuance of these services.

The returning medical veteran has received such help as the facilities of our Society could offer. The return of physicians to private practice involves many complicated problems, some relating to refresher courses, some to the ordinary economic demands of everyday living, and some to the special fields of medical practice.

The Society has done much to make the rough places smooth. The refresher courses, as materialized in spring clinics and in county and councilor district meetings, have received an impetus by the ending of the war. What has given medicine influ-

ence and importance to the public is its scientific attainment, and every effort should be made to afford opportunity to the doctor for progressively improving his abilities.

I have always contended that the doctor should be permitted to pursue his work free from artificial barriers that may be constructed by other physicians, hospitals, industrialists, and diverse organizations against him.

Much of the ammunition exploded against medicine has been found in our own ranks and in our own intolerances. The broadening of the panel systems in industrial medicine has been progressive and heartening, and the Society through its committees has done much toward erasing a condition that at one time appeared extremely formidable. The closed hospital staffs are decidedly unfair to the doctor on the outside. He was not informed of any limitations when the State licensed him to practice medicine and surgery. There should be no special privilege caste in medicine.

The scope of this report will not permit a review of the work of the many committees and officers of this Society. In the course of this meeting much of their work will be unfolded. On the whole, their work has been conspicuously able, patient, and painstaking. It is seldom in their deliberations that a personal element has visibly entered. Devotion to the interests of the whole profession has been the rule and not the exception.

The office of our Society, under the direction of our secretary, Mr. Crownhart, and his able staff, has operated with ability and efficiency. The multitudinous duties imposed upon the office have been performed with an amplitude of consideration and an exactitude of detail.

From time to time outside influences, envious of our importance, and intent on turning our skill into profits, will attempt subversive campaigns with our ranks that our disorganization may be their opportunity for control and profit. Members may be approached with offers of profitable special privileges. I have faith that no member will consent to be corrupted at the expense of his high reputation as a member of organized medicine.

At the conclusion of this year's work I am sensible to the opportunities it offered; I am not too certain of the accomplishments. However, it will be a major satisfaction to know that the work will be continued and that abler hands will direct activities for a united, militant association of physicians whose chief concern is the health services of the public.

My predecessor, Doctor Fidler, left a record of unfailing devotion to the duties imposed upon him by this office; I have complete faith that the ability and integrity of Doctor Dawson, who succeeds me, will see us through the trials of the coming year.

Our organization must stand formidably intact. We must present an unbroken front to the forces that would strike down the eagle and exalt the bear. These forces, certainly in America, are actually a small, if highly vocal, minority. No member or group is greater than the whole organization. The tail can never wag the dog. If it did, the result would not be a dog but a monstrosity. At no time in our history was the axiom more fitting than now, that "United we stand; divided we fall."

Address of President-Elect Dawson

It has been the custom for the incoming president of this Society to outline before this, the governing body of the State Society, his tentative program of activities for the year to come.

Down through the years these programs have been constructive and productive of much benefit to the people of our state. Your present incoming president has very little in the way of innovations to offer you as a program.

One of the outstanding features of President Minahan's program has been that of proposed care for the aged and those individuals who, because of physical disabilities, are unable to care for themselves. Considerable work along this line has been done by our president, his committee, and the committee of county judges which was appointed to cooperate with medicine in the program. This program, of necessity, must be one of long range. I shall consider it a privilege to continue the work started by Doctor Minahan along this line.

The coming year will be a legislative year, and one in which many problems will confront us—probably greater legislative problems than have faced us in preceding years. It will be one of the duties of this administration to carry out the mandates of this House of Delegates along legislative lines.

Down through the years medicine has attained a certain amount of legislative prestige because of decency and honesty in its methods. We can point with pride to the fact that never have we sponsored selfish legislation, nor have we opposed legislation for selfish reasons. At all times medicine has been actuated in its legislative activities by its interest in the welfare and well-being of the people of this state. It need offer no apology for any of its activities. Some of us, because of official position in the State Medical Society, have taken a considerable interest in the legislature. We believe that we have obtained and held the respect and confidence of the legislators.

Session after session, matters to be brought before the legislature have been considered seriously and thoughtfully by this body and by your Public Policy Committee. Before being presented to the legislature they have been viewed from all angles with careful thought as to the results of proposed legislation should it become law. At the last session of the legislature medicine went before that body with its house divided against itself. Incriminations and recriminations were hurled back and forth. The result was a loss of prestige which can only be regained by a singleness of purpose and a unity of action. It cannot be expected that a legislature of laymen will be able to sift out the grain from the

chaff in matters that are professional, nor will they care to do so. A divided house of medicine at the next legislative session will spell disaster.

I would stress to you the necessity of your careful consideration of any controversial matters that might come before you at this session—consideration in the light of what is best for the people of this state and best for the members of our profession. Medicine has always felt keenly its obligations to the people of the state. Its zealousness in fulfilling those obligations has at times led to disagreements as to how those obligations could best be fulfilled.

Our state is made up roughly of two groups of people—one, the large concentrated industrial group; two, the large widely scattered agricultural group. Because the perspectives of these two groups differ, there is a divergence of opinions of the two groups as to the needs of society as a whole and as to the means that should be used to attain certain ends.

The men of our profession fall naturally within the same classifications. This is true also of other groups who are divided in their opinions as to church, civic duty, and other activities. Because two men differ in perspective and opinion as to the method to be used in attaining a certain end, neither is justified in impugning the activities of the other.

Today medicine is facing the greatest crisis of its entire existence. Mighty forces are trying to accomplish the downfall of our profession as you and I know and have known it. This is a statement of existing fact, not a statement of presumption as to what we may face in the future.

If medicine goes before the coming legislature divided in its opinion as to the best interest of public welfare, you will see the beginning of the downfall of the influence of medical men in shaping the methods of medical practice among a free people.

It is the duty of this body to decide definitely that the selfish ambitions of no man nor differences in opinions of any groups of men shall cause a breach in the solid front of medicine nor widen any slight fissure that may exist at the present time. Such a breach will not only threaten medicine, but will endanger the dignity and freedom of the individual whatever his social position may be.

Our legislative bodies are made up of intelligent and thinking men. By and large they have been willing to take the advice of medicine upon all matters pertaining to the health of the people of the state. There has been no dividing line of party politics in this faith of the legislator in your representatives. It has been rightly assumed that your official spokesmen spoke for all of medicine. Only upon such an assumption can the faith of your legislator be retained. If he is not able to rely upon the accuracy of the statements of your representatives, he must of necessity seek advice elsewhere.

In fact, some of our strongest supporters in the legislature have warned us frankly that if we could not come to the legislature with a solid front we need expect their support no longer. And I would stress this fact most strongly, that when we lose the faith of the legislators we lose the faith of the body of citizens whom they represent.

Today the life of the legislator is not an easy one. Pressure group after pressure group is knocking at his door, and the amount of force exerted by these is well-nigh inconceivable to the uninitiated, especially when several combine to attain one end.

You here today hold the future of medical practice in Wisconsin in your hands. If, because of sectional strife, you allow a break to come in the solid front of medicine, the results will rightly be laid at your door. Selfishness, personal prestige, sectional gain, or aggrandizement have no place in this body. It is my hope that there will be in this meeting a complete freedom of expression of opinion, with an honesty of vote and a unity of action following your decisions. Let us leave this meeting a united Society.

Resolution Offered by the President-Elect Pertaining to the Duties of the Committee on Grievances

Doctor Dawson offered a resolution for consideration of the House, providing for expanding the duties of the Committee on Grievances as follows: Amend Chapter VII, Section 5 of the By-Laws, by adding at the end thereof a new sentence to read: "The committee shall possess similar responsibilities where request is made to investigate complaints bearing upon a member's alleged violation of any provision of the Medical Practice Act."

Appointment to Standing Committees of the Society and Announcement of Special Committee Appointments of the President

The changes in the committee structure and the appointments to committees of the Society were then announced by President-Elect Dawson, and these were reported in full in the November issue of *The Wisconsin Medical Journal.* The appointments by Doctor Dawson were approved by the House upon motion by Dr. S. E. Williams, Chippewa Falls, seconded by Dr. J. J. Gramling, Milwaukee.

REPORT OF DR. IRA R. SISK, TREASURER

For the Year Ended December 31, 1945

Doctor Sisk presented the following report which was distributed to each member of the House.

Cash on Deposit—First National Bank January 1, 1945		$ 35,777.23
Revenues		
Membership Dues	$ 65,184.65	
1945 Exhibit Space Rentals	1,800.00	
Proceeds from securities called	7,330.00	
Gains on sale of securities	145.00	
Interest Received	1,574.11	
Principal collected on Aetna Insurance Policy	1,004.40	
Checks issued in 1944 cancelled and restored in 1945	1,150.00	
Industrial Clinic Receipts	1,329.65	
Total Revenues		$ 79,517.81
Total		$ 115,295.04

REPORT OF DR. IRA L. SISK, TREAS.—Continued

Expenditures		
Constitutional Officers and Committees		
President's Travel	$ 500.00	
Council and Committees	3,924.52	
Books and Periodicals	248.10	
Delegates to A. M. A.	300.00	
Auxiliary	100.00	
Secretary's Salary	9,000.00	
Secretary's Travel	1,173.42	
Group Total	$ 15,246.04	
Staff		
Assistant Secretary's Salary	$ 4,500.00	
Assistant Secretary's Travel	217.97	
Secretarial Staff Salaries	8,153.22	
Executive Assistant to Secretary	1,295.00	
Group Total	$ 14,166.19	
Administrative Expenses		
Accounting and Insurance	$ 941.06	
Social Security Taxes	583.12	
Rent	1,800.00	
Telephone and Telegraph	1,393.23	
Supplies and Light	974.68	
Postage and Printing	2,667.99	
Fixtures and Upkeep	293.79	
Miscellaneous	1,247.90	
Group Total	$ 9,901.77	
Totals—Carried Forward	$ 39,314.00	$ 115,295.04
Membership—Special Service		
Legal	$ 1,795.77	
Special Bulletins to Members	637.23	
Blue Book Issue	750.00	
Hygeia	277.50	
Lay Publications	240.04	
Bulletins to Members	808.95	
Telephone and Telegraph	842.18	
Services, general counsel	1,500.00	
Voluntary Sickness Insurance Trials	5,533.47	
Group Total	$ 12,385.14	
Public, Industrial and Agricultural Health and Public Instruction		
Rent of Office	$ 660.00	
Preparation of Panel	456.99	
Administrative Assistant	1,995.00	
Industrial Clinics and County Programs	2,372.34	
Printing	1,145.43	
Assistant, Public Relations	1,538.73	
Publications	325.48	
Press Releases	534.00	
Radio and Special Releases	944.22	
Group Total	$ 9,972.19	
Annual Meeting, Postgraduate Centers, and Wisconsin Medical Journal		
House of Delegates Meeting	$ 1,532.02	
Postgraduate Centers	None	
Wisconsin Medical Journal	2,600.00	
Group Total	$ 4,132.02	
Other Expenditures		
U. S. Government Bonds purchased	$ 10,000.00	
1945 Exhibit Space Rental returned to Exhibitors	3,875.00	
Group Total	$ 13,875.00	
Total Expenditures		$ 79,678.35
Cash on Deposit—First National Bank, December 31, 1945		$ 35,616.69

Allocation of Cash Balance at December 31, 1945 by Funds:	
Fund "A"—General Operating	$ 18,870.14
Fund "B"—Public, Industrial, and Agricultural Health and Public Instruction	13,022.46
Fund "C"—Annual Meeting, Postgraduate Centers and Wisconsin Medical Journal	4,222.13
Fund "D"—Investment Cash (Overdraft)	(498.04)
Total Fund Balances, December 31, 1945	$ 35,616.69

Securities Owned December 31, 1945

Description	Interest Rate	Maturity Date	Face Value	Cost
U. S. Government				
U. S. Savings Defense, Series G	2½	6-1-53	$ 2,000.00	$ 2,000.00
U. S. Savings Defense, Series G	2½	6-1-54	6,000.00	6,000.00
U. S. War Savings, Ser. G	2½	9-1-54	3,000.00	3,000.00
U. S. War Savings, Ser. G	2½	6-1-55	5,000.00	5,000.00
U. S. War Savings, Ser. G	2½	1-1-56	8,000.00	8,000.00
U. S. War Savings, Ser. G	2½	8-1-56	5,000.00	5,000.00
U. S. Treasury	2½	9-15 67-72	3,000.00	3,000.00
U. S. Treasury	2½	12-15-72	10,000.00	10,000.00
Total U. S. Gov't.			$42,000.00	$42,000.00
Public Utilities				
Milwaukee Gas Light Co.	4½	3-1-67	$ 1,000.00	$ 1,057.50
Milwaukee Gas Light Co.	4½	3-1-67	2,000.00	2,000.00
Southern California Edison Co. Ltd.	3	9-1-65	2,000.00	2,080.00
Wisconsin Gas & Electric Co.	3½	4-1-66	1,000.00	1,030.00
Wisconsin Power & Light Co., Series A	3¼	8-1-71	3,000.00	3,206.25
Total Public Utilities			$ 9,000.00	$ 9,373.75
Total Securities Owned, Dec. 31, 1945			$51,000.00	$51,373.75

Report of the Secretary, Including Transmittal of Report of Committee on Hearing Defects

The secretary directed the attention of the House to a resolution which had been adopted by the State Bar Association and had been directed to other state organizations for consideration. That resolution urged the schools to undertake the development of a curricula to teach students certain of our basic and fundamental constitutional concepts of government and democracy. In addition the secretary presented the full report of Dr. W. E. Grove, Milwaukee, as chairman of the Committee on Hearing Defects as follows:

"Several meetings of the committee have been held during the year. Early in the year an attempt was made to organize the otolaryngologists of the Fox River Valley for the purpose of forming a Hearing Rehabilitation Clinic similar to that operating in Milwaukee. This was not found feasible due to the scattered location of the communities in that area. However, at the same time your committee put on a hearing conservation program before the Central Wisconsin Eye, Ear, Nose and Throat Society.

"Two of the members of your committee have been active in the work of the Milwaukee Hearing Rehabilitation Clinic. Two members of your committee are on the Board of Otological Consultants of the Milwaukee Chapter of the American Hearing Society and one on a similar board of the parent Society.

"Two members of your committee have recently met with representatives of the Milwaukee Health Department, the Board of Education of Milwaukee County, and Mr. Frank Powell of the Bureau for Crippled Children. As a result of this meeting a Conservation of Hearing program for the more than 120,000 school children of the Milwaukee metropolitan area is being organized. It is hoped

by your committee that when this program is in full operation it will serve as a pattern for the rest of the state.

"Your committee has also arranged an exhibit on conservation of hearing for the present meeting of the State Society, to be directed by Mr. Howard Carter, secretary of the Council on Physical Medicine of the American Medical Association."

Following submission of this report, the secretary detailed the status of membership as follows:

2,021	fully paid members
691	members in military service or members just returned whose dues have been prorated
31	war members
33	residents and research members
71	life and honorary members
57	delinquents
2,847	total membership

As a supplementary report to that of the Council relating to necrology, the secretary's office reported the following deaths since the date of that report:

Dr. John C. Grill, Milwaukee, a member.
Dr. Julius A. Schmidt, Milwaukee, a member.
Dr. Cletus K. Ziegler, Milwaukee, a member.
Dr. Joseph F. Kenney, Milwaukee.
Dr. B. L. Cleary, Edgerton.

Following conclusion of this portion of the report, the membership and guests of the House stood in silent tribute to the departed members of the medical profession.

Report of the Committee on Public Policy

In behalf of the committee and at the request of its chairman, the secretary read the full report of the Committee on Public Policy as follows:

The Committee on Public Policy has the responsibility of presenting to "those public health officers charged with the duty of enacting or enforcing measures in the interest of public health, all available information that may in any way assist such officers honorably to discharge their responsibilities."

While the committee functions most actively during periods in which the State Legislature of Wisconsin is in session, the now increasing extent of federal as well as state legislation, in matters pertaining to public health, causes continuous committee consideration.

With the convening of the State Legislature of Wisconsin in the early weeks of 1947, this committee has been in session to consider basic public health legislation that it believes should be sponsored in behalf of the medical profession of this state. As members are quite aware, the Society, on many occasions, has enunciated its legislative policy of the broadest character stating that any proposal made in the interest of public health is necessarily in the interest of medicine as well. There cannot be a divergence between the two.

The committee proposes to function, as it has in the past, in an effort to maintain the highest educational standards possible for those who treat the sick. To that end, on behalf of the Society, the committee will continue to support the principle of the basic science law and of medical education statutes, already in existence. It believes that it speaks the mind of the physicians of this state when it opposes compulsory health insurance, whether on a state or national level.

The committee has been concerned with certain fundamental proposals which it reports to this House as well as its attitude concerning them.

1. *Increase in Number of Health Districts.* The State Board of Health has previously directed to the attention of the medical profession, the legislature, and the public, the need for further implementing its responsibilities by increasing the number of health districts in this state. With the limited personnel that is now available and the geographic area that must be served by each district, it is manifestly impossible for the State Board of Health properly to execute its responsibilities. It must be recognized that while some health activities of the state are now in various departments, it does seem clear that the State Board of Health is the designated state agency, and properly so, in those fields of public health activity having to do with preventive medicine and with treatment delegated as a state activity. The State Department of Public Welfare is interested in public health as a custodial agent of the state. Health activities in the State Department of Public Instruction and in the State Board of Vocational and Adult Education relate only to specific fields of specialized state interests. The Committee on Public Policy, therefore, proposes that the State Medical Society actively support the program of the State Board of Health to expand its districts.

2. *Public Health Nurses and State Aid.* Under the present state law there is state aid for one county public health nurse in each county. It seems apparent to the committee that the attention of the legislature should be directed to the fact that in fields of preventive health programs as exist in Wisconsin there should be an adequate number of public health nurses provided. Therefore, your committee proposes to support legislation that would increase the amount of state aid now available in this field. The timeliness of this suggestion depends, however, on the district offices of the State Board of Health being fully staffed, particularly so far as the medical directors are concerned.

3. *Nursing Education.* It has become increasingly apparent in recent years that there is an insufficient supply of candidates for nursing education, an insufficient number of nurses for the health needs of the people of this and other states, and probably an insufficient distribution of both nurses and institutions in which nurses can be educated. This committee is aware of the feeling that exists in the medical profession as a whole throughout the state

that "something must be done." Anticipating these general problems, the State Medical Society several years ago supported legislation for the licensing of attendants in a subsidiary field of nursing. This legislation was passed but at the date of this session no such schools for licensed attendants have been organized in the state, and very few attendants have been licensed. The Society has likewise asked action by the American Medical Association to review this whole problem on a national basis, and it is the understanding of the committee that such studies and conferences are now being developed by the American Medical Association.

It should be made clear to the delegates that the authority of the State Board of Health in the field of nursing education is extremely limited. The actual authority and final determination rest chiefly in the Committee on Nursing Education. The problem before this body is whether it believes that general policies in the field of nursing education and nursing licensure should be vested primarily within the authority of educators and administrators themselves, or whether a broad view should be taken that final approval should be exercised by the State Board of Health. If the responsible agency of the state is to be one which is composed primarily of the former, then that bureau should be divorced from the State Board of Health, and the State Board of Health should by that token be removed from public responsibility. If in the public health interest it seems better that the field of nursing education be one generally within the supervision of the State Board of Health, then the statutes should be clarified and strengthened so that these activities would be an official responsibility of the latter board.

It is the belief of the committee that the latter view is the wiser, and if that view meets with the general approbation of the House, the committee will support legislation to that end.

4. *Salaries for Professional Employees of the State.* The Committee on Public Policy is appreciative of the fact that various state agencies are understaffed in their professional personnel, particularly that relating to the field of the medical practitioner. This condition in state employment is not conducive to the advancement of health standards that are within the jurisdiction of state agencies. The situation with respect to the State Board of Health must be generally appreciated by the profession. The committee notes that the Society's Committee on Mental Hygiene and Institutional Care suggests that a qualified physician be employed by the State Department of Public Welfare to inspect and supervise the medical care given in county institutions in Wisconsin that are under the jurisdiction of that particular department, and that the department itself exercise jurisdiction in the matters of inspection, education, and adoption of minimum medical standards.

That the state may function most effectively in the health responsibilities which are now its prerogatives, the committee suggests that it receive support in its proposal to assist actively in adequate studies of this phase of a larger problem, and from time to time to promote a more realistic program on the part of state government itself.

5. *Rheumatic Fever Program.* The committee notes the suggestion of the Advisory Committee on the Care of Crippled Children that the Society sponsor legislation that will provide public funds administered through the Bureau for Handicapped Children for the establishment of convalescent homes for rheumatic fever patients with essential qualifications as recommended by the State Medical Society. The committee believes this wholesome legislation and in the public health interest.

6. *State Aid—Distribution of Physicians.* This Society has on previous occasions considered the problem relating to the distribution of physicians. The war greatly disrupted both the supply and the availability of physicians. Now an increasing tendency toward specialization causes concern as to the future distribution of physicians. The committee is not convinced that the distribution of physicians is dependent upon the distribution of hospitals, nor does it think it should be. However, the committee does recognize that there are scattered areas of population within which the services of a physician are not readily available. Under present conditions, or conditions that may be anticipated in the future, it may be difficult to interest physicians in these locations without some assurance that a successful practice can be built. The Special Committee to Study the Distribution of Health Services and Sickness Care in Wisconsin reported to the 1938 House of Delegates a proposal that the Society urge upon the legislature an appropriation of $20,000 annually to be spent by the State Board of Health in appointing physicians in necessitous areas as deputy state health officers upon determination by the Board as to the areas in need. It was the committee's thought that such physicians might, by relatively modest sums, be compensated for the basic initial costs involved in establishing and maintaining office facilities in areas needing them, during the period in which a practice is being developed.

It is believed that this suggestion should be reoffered at this time, so that the State Board of Health, as well as the medical profession generally, can actively cooperate in the distribution of physicians throughout the state.

The committee has considered other matters pertaining to public health legislation. It has given consideration to certain basic requirements in the screening examination of all hospitalized patients. It has given thought to the extension and application of laws relating to the Workmen's Compensation Act and to unemployment compensation to smaller groups of employees. It has given serious consideration to the status of laws relating to the mentally ill and others. But it believes that further studies are necessitated before the Society is in a

position to commit itself upon these several propositions.

It does propose however to support actively the building project of the State Laboratory of Hygiene and if adequate legislation for the control of barbiturates can be devised nationally, the Committee on Public Policy believes that legislation should be supported in Wisconsin on the state level. It is much interested in the proposal that has emanated from President Minahan and Doctor Christofferson of the Committee on Mental Hygiene and Institutional Care relating to laws pertaining to the institutional care of the chronically ill and patients in the terminal stages of illness, who should not be confined in institutions primarily designed for the care of patients in other categories. As those proposals are further crystallized, the committee believes that they can be supported with the wholehearted enthusiasm of the profession.

The committee desires to state that it re-affirms its conviction that the high caliber attitude of the profession and its representatives toward the legislature should be continued under any circumstances. The dignity of medicine and the dignity of public health should not be handled in any but the most dignified manner.

One other subject remains to be discussed and that is the current attitude that has been expressed by certain cooperative organizations to the effect that virtually any organization should have a power to engage in prepaid medical care insurance. The committee takes the attitude that while laws of this state relating to the special activities in the field of prepaid medical and hospital expense have been devised to permit this type of activity, they have also been devised to protect the public interest by assuring proper financial, contractual and actuarial standards. The committee can do no less than express its belief that these standards should be maintained in the future.

Report of the Committee on Goiter

Dr. Arnold S. Jackson, chairman of the Committee on Goiter, submitted a further report on behalf of his committee as follows:

Since the formulation of our progress report, as published in the September issue of *The Wisconsin Medical Journal*, the Committee on Goiter has met and has given further consideration to problems in its field. On the basis of further investigation and a review of activities in goiter prevention through various county medical societies, the committee wishes to submit this supplementary report, with specific recommendations upon which the further activities of the Committee on Goiter and corresponding committees within county societies can base their program during the ensuing year:

As a preliminary statement, the Committee on Goiter wishes to re-emphasize the need for a goiter prevention program in Wisconsin. Sufficient evidence has been presented in the form of medical data to support the thesis that Wisconsin has certain geographic and geologic conditions which dictate the need for a continuous and concerted program of goiter prevention, especially among children up to the age of twenty-one.

A second fact which seems of sufficient significance to the committee to mention by way of a preliminary statement is the fact that salt fortified with a minimum of one part of iodine to 100,000 parts of salt has been recognized as an effective means of preventing goiter in children.

It is further agreed by the committee, after review of medical research on the subject, that no danger rests in supplementing the consumption of iodized salt with iodine tablets, and in special cases involving unusual growth such supplementation might seem advisable if administered under direct supervision of physicians.

Basing its report on the above three hypotheses, the Committee on Goiter wishes to make the following supplementary report:

The Committee on Goiter of the State Medical Society of Wisconsin reaffirms its opinion of the value of preventing goiter by the use of iodine. Recognizing the difficulty of introducing iodine in the diet through the use of iodine tablets, except in those cases where county health authorities have sufficient financial support to completely finance and administer such a program through all public and parochial schools, the committee reaffirms its opinion that iodized salt, if meeting certain recognized standards as to iodine content, can serve as an adequate means of prevention of goiter in children up to the age of twenty-one.

In order to assure an adequate consumption of iodine in this manner, it is recommended by the Committee on Goiter that steps be taken to make sure that all salt sold in Wisconsin has a minimum content of one part of iodine to 100,000 parts of salt, with recommendations that products sold in the state have a much greater concentration of iodine, as a means of assuring adequate protection in cases where iodized salt is held on grocers' shelves for several months before being sold. The committee further recognizes that as high a percentage as one part of iodine to 5,000 parts of salt is not deemed harmful for human consumption.

In making its recommendations concerning the adequacy of iodine in fortified salt to protect children from developing goiter, the committee is cognizant of the fact that many counties have instituted a program of distributing iodine tablets to children of elementary school age. The committee endorses the continuation of such programs, aware of the fact that in some communities the preference will be for the use of tablets, while in others iodized salt will be the means of choice.

It is felt by the committee that the continuation and extension of iodine tablet programs is added assurance that children are given the protection needed, but the committee strongly urges that prevention programs be extended to all school children

including high school, for research has demonstrated the need for such protection through ages of adolescence.

In making this recommendation it is further recognized by the Committee on Goiter that the use of preventive measures should be restricted to children without goiter manifestation, and also that they are not recommended as a treatment for adults suffering from goiter, in particular the adenomatous or nodular type.

A recent survey by the committee indicates that most of the preventive program in Wisconsin, through use of iodized tablets, is concentrated in rural areas. The extent of this protection indicates the need to conduct an aggressive educational campaign through the office of the State Medical Society, public health authorities, and the various committees on goiter of county societies, as to the value of using iodized salt as a general protective measure, and supplementing with iodine tablets where conditions indicate the wisdom and desire for added protection.

The committee is appreciative of the assistance given it by many physicians serving as members of goiter committees in county societies, and it is anticipated that during the ensuing year all county societies will appoint active committees to assist with the educational program needed to give all children of Wisconsin adequate protection against goiter through the wide use of iodized salt, and an extended program of iodine tablets as recommended in this report.

If this report is accepted the Committee on Goiter intends to conduct an extensive educational campaign on the value of iodized salt, based upon the Sevringhaus report submitted to the State Medical Society in 1941, and to meet with representatives of salt manufacturers and wholesale grocer associations to secure their active cooperation and participation in the publicity program needed.

At this point in the proceedings, the House recessed at 6:45 p. m. until 8 o'clock that evening.

Following recess, the meeting was reconvened with the supplementary report in behalf of the Credentials Committee which reported additional registration so that the total registration entitled to vote at this session was sixty delegates and nine alternates, or a total of sixty-nine. In addition to these, five alternate delegates and two past presidents were also registered in attendance. Upon motion of Doctor Hemmingsen, chairman, seconded by Dr. G. W. Carlson, Appleton, the report was accepted.

Further Suggestions Relating to Nursing Situation

Dr. Norbert Enzer, delegate from Milwaukee, was given the floor by the Speaker, and asked that such studies as were conducted concerning the nursing situation be amplified "to include an investigation concerning the salaries paid the nurses, medical technologists, x-ray technologists, and other medical services, and that such study not only concern itself with compensation in terms of money, but that it concern itself with standard hours of work, circumstances of work, and other forms of compensation such as meals, vacation, sick leave," and the like.

Report of the Committee on Extension of Insurance

Dr. H. H. Christofferson, Colby, chairman of the Committee on Extension of Insurance, summarized the report of his committee which was filed with the House of Delegates. In substance, the amplified report noted that twenty-four insurance companies were participating in the sale of the Wisconsin Plan, and that so far as physician participation was concerned, sixty-seven counties were fully participating, with approximately 50 per cent participation of active members in Milwaukee County, and partial participation in Racine, Kenosha, and Sheboygan Counties.

The plan was initiated April 1946, and as of September 1, 1946, 26,587 persons were covered, representing 10,543 subscribers and 15,944 dependents. The total premium income from this coverage was reported to be in excess of $26,000 per month.

Doctor Christofferson noted that a very detailed study would be conducted after the plan had been in operation for one year, and further reported that an advisory vote of various prepaid medical care organizations represented at the Association of Medical Care Plans in Chicago the early part of October 1946, voted to recommend the Wisconsin Plan for full voting membership by a vote of 14 to 9.

Finally the committee sought approval of the House that the Conference Committee under the Wisconsin Plan be given authority to raise the income level under the Wisconsin Plan to meet that of any other plan sponsored by the State Medical Society of Wisconsin.

Report of State Health Officer

Dr. Carl N. Neupert, state health officer, reported to the delegates a brief summary of the communicable disease picture as it then confronted Wisconsin. He reported that over a thousand cases of poliomyelitis had been diagnosed in the past year with approximately seventy deaths. He reported more non-paralytic cases than usual, and indicated that this signified an alertness on the part of the attending physicians in their diagnostic procedure. He reported an increase in diphtheria, with 109 cases and eighteen deaths to the date of his report against a total of 110 cases and six deaths in 1944.

He explained problems confronting the Board which indicated the problem in handling the requests made of the state and cooperative laboratories. With reference to the blood plasma program being developed, he reported that the Board had studied this situation for about five years, and expects to go before the legislature as a result of this and other problems, requesting enough money to build buildings sufficient to handle the activities in connection with the Board's laboratory procedures.

Supplementary Report of the Council on Medical Service and Public Relations

On behalf of the Council on Medical Service and Public Relations Secretary Crownhart presented a resolution, the effect of which was to provide for the expiration of the term of each appointed member of the Council during each year. Appointments made in 1946 under the terms of the resolution would be for one to five years as designated by the incoming president.

Reference of Committee Reports, Supplementary Reports, and Other Matters Before the House

Speaker Cary announced that the various reports had been referred to the reference committees as follows:

To the Reference Committee on Resolutions:

1. The majority report, the minority report, and all material submitted by the Special Committee of the House of Delegates on Prepaid Medical Care.
2. The five resolutions submitted by the Medical Society of Milwaukee County.
3. The resolution relating to the EMIC program submitted by Dr. W. C. Stewart of Kenosha.
4. The resolution submitted by Doctor Barnes of Waukesha County relating to the dues of the State Medical Society. Under the Constitution and By-Laws, the subject of finances and dues is also referred to that committee.
5. Four resolutions submitted by the Council, dealing with a Section on General Practice; commending the Council on Medical Education and Hospitals of the A. M. A.; regarding interscholastic football for junior high school students; and providing for local, county, district, or regional full-time health services.

To the Reference Committee on Reports of Officers:

1. Report of the Council.
2. Report of the President.
3. Report of the President-Elect.
4. Report of the Treasurer.
5. Report of the Secretary.
6. Report and resolution, Council on Medical Service and Public Relations.
7. Report of the Committee on Public Policy.
8. Report of the State Health Officer.
9. Report of the delegates to the American Medical Association.

To the Reference Committee on Reports of Standing Committees:

1. Committee on Cancer.
2. Advisory Committee on Care of Crippled Children.
3. Committee on Coordination of Medical Services.
4. Committee on Goiter.
5. Committee on Health and Public Instruction.
6. Committee on Industrial Health.
7. Committee on Maternal and Child Welfare.
8. Committee on Mental Hygiene and Institutional Care.
9. Committee on Rural Health and Accident Prevention.
10. Committee on Tuberculosis and Chest Diseases.
11. Council on Scientific Work.
12. Committee on Extension of Insurance.

Election of Committee on Nominations

The House recessed for a brief time, permitting delegates from each councilor district to caucus on their nominees for membership on the Committee on Nominations. Each district, following the recess, reported its nominees and by vote of the House, on motion of Dr. H. H. Christofferson, variously seconded, the following were designated members of the Committee on Nominations:

District	*Nominee*
1	H. T. Barnes, Delafield
2	T. C. Hemmingsen, Racine
3	M. W. Stuessy, Brodhead
4	E. C. Howell, Fennimore
5	C. J. Weber, Sheboygan
6	D. J. Twohig, Fond du Lac
7	R. L. MacCornack, Whitehall
8	A. A. Cantwell, Shawano
9	A. M. Christofferson, Waupaca
10	S. E. Williams, Chippewa Falls
11	J. W. McGill, Superior
12	R. F. Purtell, Milwaukee
13	O. S. Tenley, Wabeno

The secretary announced that the Committee on Nominations would meet the next morning and would remain, pursuant to rule earlier adopted, in open session for one hour to hear members of the Society who might wish to bring suggestions before them. After further announcements the chair entertained a motion to adjourn, made by Dr. H. H. Christofferson, seconded by Dr. Charles Fidler, and the House adjourned at 8:45 p. m.

SECOND SESSION OF THE HOUSE

Monday Evening, October 7, 1946

The second session of the House was convened at 5:30 p. m., Dr. E. C. Cary, speaker, presiding. Dr. T. C. Hemmingsen, Racine, chairman of the Credentials Committee, reported verification of the registration of thirty-nine delegates and nine alternates entitled to vote at this session, and upon his motion, seconded by Dr. A. C. Engel, New Holstein, the report was accepted.

The next order of business was the report of the Reference Committee of the House on Reports of

Officers, composed of Drs. A. M. Christofferson, Waupaca, chairman; W. A. Ryan, Milwaukee; S. E. Williams, Chippewa Falls; and L. M. Lundmark, Ladysmith.

The committee recommended acceptance of the report of the Council as published in *The Wisconsin Medical Journal* and such portions of the supplementary report as were referred to it in the preceding session, and added the recommendation that the Council announce the date and place of its meetings in advance whenever possible to permit members of the Society having particular matters that they might wish considered by it to have that opportunity of referral in a more timely fashion than is now possible. On motion of Doctor Christofferson, seconded by Dr. H. H. Christiansen, Wausau, the motion was carried unanimously.

The next portion of the report urged cooperation of the profession with the Committee on War Records and the Conference Committee on Open Panels and upon motion of Doctor Christofferson, seconded by Dr. Forrester Raine, Milwaukee, this portion of the report was carried.

The committee reported that it viewed the president's report as one indicating his concept of deep and sincere responsibility, and that President Minahan was deserving of high commendation for his loyal and unselfish devotion. Upon motion of Doctor Christofferson, variously seconded, this portion of the report was adopted by unanimous and rising vote, with audience applause.

Doctor Christofferson then presented the report of the committee with reference to the address of the president-elect. It expressed confidence that under his leadership medicine would close ranks during the next year, and specifically approved the resolution presented by the president and relating to the duties of the Committee on Grievances. On motion of Doctor Christofferson, seconded by Dr. G. W. Carlson, Appleton, this portion of the report was adopted and the amendment was passed.

Upon motion of Doctor Christofferson, seconded by Dr. H. Kent Tenney, Madison, the report of the secretary, as printed in *The Journal* and as supplemented, was accepted.

Doctor Christofferson then reported the committee's approval of the work of the Council on Medical Service and Public Relations, and its belief that the Subcommittee on Nursing Problems should continue its activities. He then moved adoption of this portion of the report which was seconded by Dr. T. C. Hemmingsen, Racine.

Dr. Norbert Enzer, Milwaukee, then asked the floor and renewed the suggestion he had made the previous session to the effect that the subcommittee include other types of technical services which are adjuncts to the practice of medicine in its study, and specifically to include medical technologists, radiological technologists, physiotherapists, and the like, and that the committee concern itself with the problems of wages, salaries, hours of work, circumstances of work, vacation periods, sick leave, and the like. The amendment was accepted by Doctor Christofferson and the second, and the motion as amended was carried unanimously.

The Reference Committee then reported on the report of the Committee on Public Policy, and stated that the Reference Committee believed that the attitude of the Committee on Public Policy with reference to the basic science law and the medical education statutes now in existence should be supported, and so moved. Upon second by Dr. Norbert Enzer, the motion was put to a vote and carried unanimously.

The chairman of the Reference Committee then reported acceptance of the proposal to increase the number of health districts as outlined by the Committee on Public Policy and the state health officer, and on his motion, seconded by Dr. R. L. MacCornack, Whitehall, this portion of the report was carried unanimously.

Doctor Christofferson then reviewed the proposal of the Committee on Public Policy to extend the present program of state aid for county public health nurses. On motion of the chairman, seconded by Dr. J. G. Hoffmann, Hartford, the motion was put to a vote and carried unanimously.

In behalf of the Reference Committee Doctor Christofferson expressed the belief that the proposal of the Committee on Public Policy to strengthen authority of the State Board of Health in nursing education and licensure, should be supported by the House, and upon his motion, seconded by Dr. A. J. McCarey, Green Bay, this portion of the Reference Committee's report was adopted.

The Reference Committee next reported support of the proposal of the Committee on Public Policy to assist in adequate studies of state professional employees' salary levels. Upon motion of the chairman, seconded by Dr. Norbert Enzer, Milwaukee, this portion of the Reference Committee's report was accepted.

The next portion of the Reference Committee report suggested reaffirmation of the position of the Society first taken in 1938, providing for state assistance in the distribution of physicians and upon motion of the chairman, seconded by Dr. C. M. Echols, Milwaukee, the motion was put to a vote and carried.

Doctor Christofferson, as chairman of the Reference Committee, stated that the balance of the report of the Committee on Public Policy speaks well for the committee's judicious attitude and represents a program that should be supported. On his motion, seconded by Dr. Arnold Barr, Port Washington, this portion of the Reference Committee's report was accepted.

The Reference Committee then stated that it approved the report of Doctor Neupert of the State Board of Health and called attention to the grossly understaffed condition of that Board with respect to district health officers, and urged remedial action

at the earliest possible moment. Upon motion of the chairman, seconded by Dr. H. Kent Tenney, Madison, this portion of the report was carried unanimously.

With respect to the method of the reporting of the delegates to the American Medical Association, the Reference Committee reported its approval and expressed its belief that it should be continued in the future. Upon motion of the chairman, seconded by Dr. C. M. Echols, Milwaukee, the motion was put to a vote and carried unanimously.

The Reference Committee then expressed its opinion that considerable good can be derived by immediate study of veteran problems through proper committees of the State Medical Society, and moved that such studies should be so conducted. Upon motion of the chairman, Doctor Christofferson, seconded by Dr. J. W. McGill, Superior, the motion was put to a vote and carried unanimously.

Report of Reference Committee on Standing Committees

The next Reference Committee to report was the Reference Committee on Reports of Standing Committees, composed of Dr. D. J. Twohig, Fond du Lac, chairman; and Drs. Arnold Barr of Port Washington, H. E. Kasten of Beloit, and C. M. Echols of Milwaukee.

Doctor Twohig, reporting in behalf of the committee, stated that the work of the Committee on Cancer in its formulation of a special cancer report form for use in Wisconsin met with the approval of the committee, and urged cooperation of physicians, hospitals, and county medical societies with the survey. The committee likewise expressed its belief that physicians should avail themselves of the opportunity in the field of cancer detection by attending the series of traveling clinics being planned by the Committee on Cancer.

On motion of the chairman, seconded by Dr. M. W. Stuessy, Brodhead, this portion of the Reference Committee report was adopted unanimously.

The Reference Committee next reported its acceptance of the report of the Advisory Committee on the Care of Crippled Children with respect to the care of spastics and poliomyelitis cases, and endorsed the recommendation of that committee that legislation be sponsored providing adequate funds for the establishment of convalescent homes for rheumatic fever patients. On motion of the chairman, seconded by Doctor Gramling, Milwaukee, this portion of the report was adopted.

The report of the Committee on Coordination of Medical Services was next reviewed and the Reference Committee reported endorsement of the proposal to publish in *The Wisconsin Medical Journal* certain procedural aspects of the management of these institutions. On motion of Doctor Twohig, seconded by Dr. S. A. Morton, Milwaukee, this portion of the Reference Committee report was adopted.

Doctor Twohig, in behalf of the Reference Committee, then reviewed the report of the Committee on Goiter, and commended the committee's proposal to conduct an extensive educational campaign on the value of iodized salt, and upon his motion, seconded by Dr. J. G. Hoffmann, Hartford, this portion of the Reference Committee report was accepted unanimously.

With reference to the report of the Committee on Health and Public Instruction, the Reference Committee emphasized the growing importance of public contacts through press and radio, and recommended that the Council of the State Medical Society be urged to provide sufficient funds so that a physician may assist to an even greater degree than in the past in this field of activity. On motion of Chairman Twohig, seconded by Dr. H. H. Christofferson, Colby, this portion of the Reference Committee report was accepted.

The Reference Committee next reported with reference to the Committee on Industrial Health, and recommended that county medical societies work to effect a closer relationship with management, labor, and industrial nurses. On motion of Doctor Twohig, seconded by Dr. Aaron Yaffe, Milwaukee, the motion was carried.

Doctor Twohig next reported the endorsement of the Reference Committee to the recommendation of the Committee on Maternal and Child Welfare regarding the need for legislative action for adequate salaries for district health officers and expressed the opinion that when the present child health survey is completed, the Committee on Maternal and Child Welfare should be permitted to present a strong and realistic health program in that particular field. On motion of chairman Twohig, seconded by Dr. H. E. Kasten, Beloit, this portion of the report was carried.

The Reference Committee then reported with reference to the report of the Committee on Mental Hygiene and Institutional Care, and moved that its recommendations with reference to a qualified and fit physician to be employed by the State Department of Public Welfare, salary levels for physicians associated with county institutions, and the development of special institutions for the care of the aged ill and seniles be accepted. The chairman so moved and, upon second by Doctor Gramling, Milwaukee, the motion was put to a vote and was carried.

The Reference Committee next reported the report of the Committee on Rural Health and Accident Prevention. Upon motion of Doctor Twohig, seconded by Dr. Norbert Enzer, Milwaukee, this portion of the report was carried.

The Reference Committee then reported the excellent work of the Council on Scientific Work, and the activities in connection with *The Wisconsin Medical Journal*, and moved that the report be accepted with appreciation for the efforts of the Council on Scientific Work. Upon second by Doctor Gramling, Milwaukee, the motion was carried.

The chairman of the Reference Committee then reported support to the suggestion of the Committee on Tuberculosis and Chest Diseases that school boards have legal authority to expend public funds for financing chest examinations for teachers, and moved that this portion of the Reference Committee report be accepted, which motion was carried unanimously upon second by Dr. G. W. Carlson, Appleton.

The Reference Committee commended the Committee on Extension of Insurance for its report, and urged adoption by the House of the resolution giving it authority to raise the income level under the Wisconsin Plan to meet that of any other plan sponsored by the State Medical Society of Wisconsin. On motion by Doctor Twohig, seconded by Dr. R. G. Baker, Tomahawk, the report was carried.

Chairman Twohig reported Reference Committee support to the Committee on Hearing Defects, and upon his motion, seconded by Dr. Forrester Raine, Milwaukee, this portion of the Reference Committee report was accepted.

The reports of both Reference Committees as adopted by the House were accepted in their entirety by specific motion and the House adjourned at 6:00 p. m. to permit attendance at the special dinner honoring veteran members of the Society.

THIRD SESSION

Tuesday, October 8, 1946

The House of Delegates was convened in its third session, Dr. E. C. Cary, speaker, presiding, at 8:55 a. m., Tuesday, October 8, 1946.

The Credentials Committee reported the registration of forty-two delegates and seven alternate delegates entitled to vote at this session of the House, and reported the appointment of Dr. E. E. Kidder, Stevens Point, to act as delegate from the Portage County Medical Society in place of the regular delegate and alternate delegate who were unable to attend. In addition to the forty-nine delegates reported as entitled to vote, the Credentials Committee reported the registration of seven alternate delegates and two Councilors. On motion of Chairman Hemmingsen, seconded by Dr. R. F. Purtell, Milwaukee, the report of the Credentials Committee was accepted.

Secretary Crownhart then reported that, because of questions that had been presented to the Credentials Committee, the secretary's office, and others, the following procedures had been determined upon for calling the roll at this or any other session of the House, unless the secretary was instructed otherwise. The following was then reported:

1. If a delegate registers but is absent for some portion of the House, his alternate delegate cannot vote. Once the delegate registers for one of the three sessions, he is the accredited representative of the county society for the duration of that session.

2. If an alternate delegate first registers with credentials that have been supplied him, and is recorded on the report of the Credentials Committee, and some time during the course of the session the regular delegate appears, it is the alternate delegate who is entitled to vote.

3. An alternate delegate is alternate for a specific regular delegate and cannot serve as a "roving" alternate delegate.

4. There is no provision recognizing bloc voting by a county society. On roll call, individual delegates or alternate delegates or specially appointed delegates will be specifically polled as to their vote.

Dr. J. W. Fons, Milwaukee, then asked whether the request of the Dane County Medical Society that their alternate delegates be designated as roving delegates was out of order, and the question was answered in the affirmative by the secretary. Dr. C. O. Vingom, Madison, then asked whether further registrations would be permitted by the Credentials Committee, and the secretary answered in the affirmative.

Report of Nominations Committee and Election of Officers

Speaker Cary directed attention of the House to the fact that the first order of business at the third session is the report of the Committee on Nominations, which does not preclude additional nominations being made on the floor. Dr. Robert F. Purtell, Milwaukee, chairman of the Nominating Committee, was then recognized and submitted the slate proposed by the Nominating Committee as follows:

President-Elect: Dr. William D. Stovall, Madison

Speaker of the House: Dr. Gunnar Gundersen, La Crosse

Vice-Speaker of the House: Dr. A. A. Cantwell, Shawano

Delegate to the American Medical Association: Dr. S. E. Gavin, Fond du Lac

Delegate to the American Medical Association: Dr. James C. Sargent, Milwaukee

Alternate delegate to the American Medical Association: Dr. L. O. Simenstad, Osceola

Alternate delegate to the American Medical Association: Dr. E. J. Carey, Milwaukee

Chairman Purtell then stated: "The Nominating Committee wishes to add one more request, that this House give consideration to keeping this or some subsequent Speaker for a term of years, rather than rotating the position of Speaker of the House."

Speaker Cary then called for other nominations for the office of President-Elect. On motion of Dr. C.O. Vingom of Madison, seconded by Dr. H. H. Christofferson, Colby, the secretary was directed to cast the unanimous ballot of the House for Dr. William D. Stovall, president-elect of the State Medical Society. The secretary then announced that the ballot had been so cast.

Speaker Cary appointed as a committee to notify Doctor Stovall of his election, Dr. Robert F. Purtell, Milwaukee; Dr. J. S. Supernaw, Madison; and Dr. J. G. Hoffmann, Hartford.

The Speaker then called for other nominations for the office of Speaker of the House. None being received, Dr. J. W. Truitt, Milwaukee, moved that nominations be closed and that the secretary cast the unanimous ballot of the House for Dr. Gunnar Gundersen, the nominee of the Committee on Nominations. Dr. C. J. Weber, Sheboygan, seconded the motion which was carried unanimously, and the secretary announced the unanimous ballot of the House had been cast for Dr. Gunnar Gundersen as Speaker.

Speaker Cary then called for other nominations for the office of Vice-Speaker and, none being received, Dr. J. W. Fons, Milwaukee, moved that the nominations be closed and the unanimous ballot of the House be cast for Dr. A. A. Cantwell for vice-speaker. On second of Dr. T. C. Hemmingsen of Racine, the motion was put to a vote and carried unanimously.

Speaker Cary then called for other nominations for delegate to the American Medical Association and, none being received, Dr. C. J. Weber, Sheboygan, moved that nominations be closed and that the unanimous ballot of the House be cast for Dr. S. E. Gavin. Upon second of Dr. C. M. Echols, Milwaukee, the motion was put to a vote and carried unanimously, with the secretary then announcing the unanimous ballot of the House being cast for Doctor Gavin.

Speaker Cary then called for other nominations for delegate to the American Medical Association, and, none being received, Dr. H. E. Kasten, Beloit, moved with Dr. J. W. Fons, Milwaukee, seconding, that the nominations be closed and the unanimous ballot of the House be cast for Dr. James C. Sargent as delegate to the American Medical Association. The motion was put to a vote and was carried unanimously, and the secretary announced the ballot of the House being cast for Doctor Sargent.

The Speaker called for other nominations for alternate delegate to the American Medical Association. None being received, Dr. S. E. Williams, Chippewa Falls, moved, which motion was severally seconded, that nominations be closed and that the unanimous vote of the House be cast for Dr. L. O. Simenstad of Osceola. The secretary then so announced.

The speaker then called for further nominations with reference to the second alternate delegate to the American Medical Association and, none being received, Dr. R. L. MacCornack, Whitehall, seconded by Dr. C. J. Weber, Sheboygan, moved that the nominations be closed and that the unanimous vote of the House for Dr. Eben J. Carey, Milwaukee, as alternate delegate to the American Medical Association, be cast. The secretary then so announced.

The next order of business was the adoption of the place of the next annual meeting and, upon unanimous vote, Milwaukee was so chosen.

Election of Councilors

The following councilors were elected: Dr. C. O. Vingom, Madison, to succeed himself as councilor in the third district. The nomination was made by Dr. H. Kent Tenney, Madison, seconded by Dr. H. E. Kasten, Beloit. Upon motion of Dr. E. F. Tierney, Portage, variously seconded, unanimous ballot of the House was cast for Doctor Vingom.

Dr. E. H. Spiegelberg of Boscobel was nominated by Dr. George Parke, Viola, to succeed himself as councilor from the fourth district. On motion of Dr. C. M. Echols, Milwaukee, variously seconded, a unanimous ballot was cast for Doctor Spiegelberg.

Dr. A. H. Heidner, West Bend, was nominated to succeed himself in the fifth district by Dr. C. J. Weber, Sheboygan, and upon motion of Dr. A. C. Engel of New Holstein, seconded by Doctor Weber, the unanimous ballot of the House was cast for Doctor Heidner.

Dr. S. E. Gavin was renominated by Dr. D. J. Twohig, Fond du Lac, to succeed himself as councilor in the fifth district, and Dr. A. J. McCarey of Green Bay moved that nominations be closed and that the unanimous ballot of the House be cast for Doctor Gavin. The secretary so reported the ballot.

Dr. J. W. Truitt, Milwaukee, of the twelfth district was nominated as councilor by Dr. Norbert Enzer and, upon motion of Dr. J. W. Fons, severally seconded, the secretary was instructed to cast the ballot of the House for Doctor Truitt, which was so recorded.

Report of the Committee on Resolutions

The Speaker next called for the report of the Committee on Resolutions, Dr. Karl H. Doege of Marshfield, chairman. A motion was made by Dr. H. T. Barnes, Delafield, seconded by Dr. S. O. Lund of Cumberland, that the House go into executive session. After discussion of the motion by Doctor Enzer of Milwaukee, the motion was put to a vote and was declared lost. Dr. Karl Doege was then recognized.

Doctor Doege announced that the report of his committee would first concern itself with the five resolutions that had been submitted by the Medical Society of Milwaukee County. He announced that the Reference Committee recommended the adoption of the substitute resolution offered by Dr. H. Kent Tenney with reference to the study of the relationship of the State Medical Society and component county medical societies, with the addition of a proviso that no officer of the Society be eligible for membership on the Committee.

The resolution as presented by the Reference Committee was then read in full:

Resolved: That a committee be selected, as hereinafter provided in these resolutions, to study and consider the relationship of the component county medical societies to the State Medical Society of Wisconsin;

Resolved: That the members of the aforesaid committee be appointed from each county medical

society or societies equal to the number of councilors to which such county medical society or societies shall be entitled. The appointment shall be made by the incoming president of the State Medical Society subject to approval of the House of Delegates.

Resolved: That the committee shall complete its studies and make its final report and recommendations to the next regular annual session of the House of Delegates.

Be it further resolved: That no officer of the State Medical Society shall be eligible for membership on the aforesaid committee.

Doctor Doege moved adoption of the report of the Reference Committee which was severally seconded and was carried unanimously.

The Reference Committee next reported that the resolution offered by the Medical Society of Milwaukee County pertaining to the election of councilors constitutes an amendment to the Constitution and, under the provisions of the Constitution, must be laid over until the 1947 Annual Session. At the request of several delegates the resolution was read as follows:

Resolved: That the Constitution of the State Medical Society of Wisconsin, and more particularly Section 2 of Article IX thereof, shall be and said Constitution is hereby amended by adding to said Section 2 the following:

"Each councilor shall be nominated and elected at the annual meeting of the House of Delegates only by the elected delegates of the county medical society or societies in the district for which he is nominated."

The Reference Committee next reported with respect to the resolution requiring two annual meetings of the House of Delegates and stated that "inasmuch as adequate provision is now made for special sessions of the House of Delegates either at the request of twenty members or by action of the Council, such provision is deemed adequate for the Society's needs and best interests without adding the requirement that a supplemental annual meeting be made mandatory."

Chairman Doege moved rejection of the resolution and upon second by Dr. H. H. Christofferson, the motion was put to a vote and carried unanimously.

The Reference Committee then reported on the resolution asking for a detailed report by the Committee on the Extension of Insurance regarding the Wisconsin Plan. Doctor Doege stated that in light of the report of the Committee on Extension of Insurance, furnishing such data as was now available, representatives of the Medical Society of Milwaukee County themselves recommended that the resolution calling for a detailed report be tabled. The Reference Committee concurred in that opinion and Doctor Doege so moved which, upon second by Dr. C. M. Echols, Milwaukee, was put to a vote and carried unanimously.

Chairman Doege next reported as to the resolution proposing to limit the chairman of the Council to two annual terms of office, whether or not consecutive. Chairman Doege reported that it was felt by the Reference Committee that this limitation was not in the best interests of the Society and that the Council was the best judge of the question of reelecting the chairman, and moved rejection of the resolution, seconded by Dr. S. E. Williams, Chippewa Falls, and carried unanimously.

Chairman Doege then reported with reference to the resolution introduced by Dr. H. T. Barnes of Delafield at the request of the Waukesha County Medical Society that the annual membership dues in the State Medical Society be lowered to the prewar level. After consideration of the budget and of the problems confronting the profession and its adjustments to certain current programs, Chairman Doege reported that the Reference Committee, considering this resolution as merely advisory, submitted the following resolution for action at this time:

Resolved: That the budget be approved and that the annual dues for the year 1947 shall be established at $35.

Dr. R. L. MacCornack, Whitehall, seconded the motion which was put to a vote and carried unanimously.

Chairman Doege then reported the resolution relating to the terms of members of the Council on Medical Service and Public Relations, providing for the substitution of a five-year term for its five appointed members rather than the present one-year terms. This recommendation was supported and the resolution as offered by the Council was recommended for adoption, together with striking the word "annually" as it appeared in the fifth line, Section 3, Chapter VII of the By-laws, printed in the 1946 Blue Book issue of *The Wisconsin Medical Journal.* Doctor Doege so moved, Dr. R. F. Purtell of Milwaukee seconded, and the motion was carried unanimously.

Chairman Doege then reported that Dr. T. C. Hemmingsen, delegate from the Racine County Medical Society, had appeared before the Reference Committee and asked that it sponsor a resolution adopted by the Racine County Medical Society asking that the House instruct the Insurance Committee of the State Medical Society to revise the Wisconsin Plan and the present Milwaukee Surgical Care plan so that such would be indemnity plans without commitment of the profession to full coverage benefits. Chairman Doege, in behalf of the Reference Committee, moved reference of this resolution to the Committee on Medical Economics and Voluntary Sickness Insurance, which motion upon second by Dr. J. J. Gramling of Milwaukee was carried unanimously.

Chairman Doege next reported as to the resolution relating to the Emergency Maternity and Infant Care program, and moved its adoption with the first paragraph to be stricken. This motion was seconded by Dr. W. C. Stewart of Kenosha. Dr. H. Kent Tenney, Madison, asked that the resolution be read

in its entirety, which was done by the chairman as follows:

WHEREAS, the experience of the public and the profession with the Emergency Maternity and Infant Care program has been very unsatisfactory and extravagant, and

WHEREAS, the members of the Wisconsin State Medical Society are positively committed to the confidential relationship and freedom of enterprise in the medical profession, and

WHEREAS, we direct the attention of the people of this state to the contribution that has been made by the medical profession to their general welfare and to the present high standards of medical practice, and

WHEREAS, we again direct their attention to the Wisconsin Plan and the Wisconsin Physicians Service programs that will render unlimited surgery, obstetrics, and associated x-ray and anesthesia including passing medical service to the low income class group; now, therefore, be it

Resolved: That this House of Delegates hereby express our opposition to all efforts by propaganda, legislation or executive sponsorship to socialize or nationalize the medical profession and likewise refuse to participate.

Doctor Tenney then moved that the motion of Doctors Doege–Stewart be amended by striking from the resolution as proposed the words "and likewise refuse to participate." This motion was seconded by Dr. O. W. Saunders, Green Bay. After discussion Dr. J. K. Trumbo, Wausau, moved the resolution be tabled. Dr. H. H. Christiansen, Wausau, seconded the motion. Speaker Cary announced that a motion to table is not debatable and put the motion to a vote which was carried.

Introduction of the President-Elect

Dr. R. F. Purtell, Dr. J. S. Supernaw, and Dr. J. G. Hoffmann then presented the president-elect, Dr. William D. Stovall, who addressed the House briefly, expressing his appreciation for the honor given him and telling the House that he would lend his efforts to the development and further application of the principles for which the State Medical Society of Wisconsin had long stood.

Continuation of the Report of the Reference Committee on Resolutions

Chairman Doege next announced that the four resolutions incorporated in the supplementary report of the Council would next be reported by the Reference Committee.

Chairman Doege read a communication from Dr. George F. Lull, secretary and general manager of the American Medical Association, reciting the action of that association in establishing an individual Section on the General Practice of Medicine, and requesting similar consideration on behalf of state medical societies. Chairman Doege reported that the Reference Committee believed that similar action should be taken under the provisions of Chapter XII of the By-Laws, and so moved, which upon second by Dr. E. D. Sorenson, Elkhorn, was unanimously carried.

Chairman Doege then reported on the resolution offered to the supplementary report of the Council by Dr. Spencer Beebe of Sparta to the effect that the State Medical Society approve and commend the work of the Council on Medical Education and Hospitals of the American Medical Association and urge its continuation in this field.

Chairman Doege stated that, while this resolution incorporated a very worthy objective, it was not one necessarily requiring formal action of the Society at this particular time and, for that reason, moved that the resolution be tabled. This motion was seconded by Dr. F. E. Drew, Milwaukee, and unanimously carried.

Chairman Doege then reported with respect to the resolution offered by the Committee on School Health through the supplementary report of the Council as follows:

WHEREAS, it has been suggested in some educational circles in Wisconsin that students of junior high school age be permitted to engage in interscholastic football competition, and

WHEREAS, such contemplated activity has health implications of concern to parents, educators and physicians alike, and

WHEREAS, the Joint Committee on Health Problems in Education, representative of the National Education Association and the American Medical Association, in 1945 specifically recommended that all interscholastic competition be limited to senior high school students and that "junior high school boys should not compete in American football" (either on an interscholastic or intramural basis), and

WHEREAS, prominent pediatricians and orthopedic specialists contacted in reference to this problem were unanimous in their opinion that it is harmful, physically and emotionally, for boys of junior high school age to compete in interscholastic competition in football; therefore be it

Resolved: That the State Medical Society go on record as condemning the contemplated expansion of interscholastic competition below the senior high school level, and that in reference to American football competition should be limited to students of senior high school age, under competent coaching direction, equipped with adequate safeguards and under competent medical direction; and be it further

Resolved: That this resolution be transmitted to the Superintendent of Public Instruction, the School Health Council of Wisconsin, and the Wisconsin Congress of Parents and Teachers, so that parents and educators alike will have full knowledge of the attitude of the State Medical Society of Wisconsin on the question of extending a program of interscholastic competition, and particularly competition in football, below the senior high school level.

On behalf of the committee, Chairman Doege moved adoption, seconded by Dr. M. W. Stuessy, Brodhead, which motion was carried unanimously.

Chairman Doege then reported on the resolution pertaining to modern public health organizations and, in behalf of the committee, moved that the State Medical Society be on record to similar effect,

which upon second by Dr. C. J. Weber of Sheboygan, was unanimously carried.

Chairman Doege then stated the report of the Reference Committee with respect to the report pertaining to prepaid medical care as follows:

In connection with the filing of its majority report and recommendations, six members of the Special Committee of the House of Delegates on Prepaid Medical Care Plans offered a resolution, the effect of which is to establish the Wisconsin Physicians Service and to adopt the majority report and recommendations.

After careful consideration of the arguments presented at the open hearing held by this committee, and after study of both the majority and minority reports, in an effort to do what is deemed to be in the best interests of both the public and the profession of this state, it was the considered judgment of your committee that the resolution be adopted, and with it the majority report of the above Special committee.

After so reading the report, Chairman Doege moved adoption, seconded by Dr. L. V. Littig, Madison.

Following discussion by Dr. C. O. Vingom, Madison, and Dr. Norbert Enzer, Milwaukee, Doctor Enzer then moved that the original motion of Doctors Doege–Littig be amended, that the minority report be substituted for the recommendation of the committee. This motion was seconded by Dr. J. J. Gramling, Milwaukee.

Dr. W. C. Stewart then moved that the special committee be ordered back into session to study possible compromises. This motion was seconded by Dr. A. A. Cantwell.

Speaker Cary called for a rising vote. The secretary noted that thirty-eight voted in favor of recommitment, with thirty-seven voting against. Dr. W. A. Ryan raised the point of order as to the vote necessary to pass or refuse the motion of Doctor Stewart. Dr. J. K. Trumbo of Wausau asked for a roll call of the House. The secretary announced that at the time of the roll call there were not seventy-five delegates registered and reported through the Credentials Committee, but that seventy-five delegates had voted.

Speaker Cary called for a supplementary report of the Credentials Committee, which reported that twenty-six additional members had been accredited so that the total registration at the point stood sixty-seven delegates and eight alternate delegates, or a total of seventy-five, and moved acceptance of the report. Dr. F. E. Drew of Milwaukee seconded, and the motion was carried unanimously.

Doctor Enzer moved that the House of Delegates instruct the special committee to go into session at once and report back to the House at 5 o'clock. Doctor Drew, Milwaukee, seconded. Dr. J. K. Trumbo rose to a point of order, demanding a roll call of the House on the original motion offered by Doctor Stewart. Doctor Enzer stated his belief that the request for a roll call was out of order. Dr. H. E. Kasten moved that a roll call be ordered, which motion was severally seconded. Doctor Ryan, Milwaukee, stated his belief that any delegate was entitled to ask for a poll of the delegates on any question. The Speaker ordered the secretary to call the roll of the House. Doctor Tenney, Madison, asked that the motion before the House be stated prior to roll call. Secretary Crownhart stated that "the motion before the House is to recommit the question to the special committee of the House of Delegates which brought in the minority and majority report, or to a substitute committee. The motion is whether you desire to recommit the minority and majority reports. Those voting 'Yes' will favor those reports being committed, and those voting 'No' are opposed to committing the reports."

The roll was called as follows:

	Yes	*No*	*Not Voting*
W. E. Bargholtz, Ashland		x	
S. O. Lund, Cumberland		x	
O. W. Saunders, Green Bay		x	
A. J. McCarey, Green Bay	x		
A. C. Engel, New Holstein		x	
S. E. Williams, Chippewa Falls		x	
H. H. Christofferson, Colby		x	
E. F. Tierney, Portage		x	
J. S. Supernaw, Madison		x	
F. F. Bowman, Madison		x	
N. A. Hill, Madison		x	
T. A. Leonard, Madison		x	
H. Kent Tenney, Madison		x	
F. G. Bachhuber, Mayville	x		
J. W. McGill, Superior		x	
W. R. Manz, Eau Claire		x	
D. J. Twohig, Sr., Fond du Lac	x		
O. S. Tenley, Wabeno		x	
E. C. Howell, Fennimore		x	
M. W. Stuessy, Brodhead		x	
L. J. Seward, Berlin		x	
S. B. Marshall, Hollandale		x	
G. E. Eck, Lake Mills	x		
C. A. Vogel, Elroy		x	
W. C. Stewart, Kenosha	x		
J. C. Fox, La Crosse		x	
C. E. Zellmer, Antigo		x	
R. G. Baker, Tomahawk		x	
E. C. Cary, Reedsville	x		
H. H. Christensen, Wausau		x	
J. M. Bell, Peshtigo	x		
H. J. Gramling, Milwaukee	x		
E. L. Bernhart, Milwaukee	x		
Aaron Yaffe, Milwaukee	x		
T. J. Aylward, Milwaukee	x		
H. R. Foerster, Milwaukee	x		
Joseph Lettenberger, Milwaukee	x		
J. J. Gramling, Jr., Milwaukee	x		
W. A. Ryan, Milwaukee	x		
F. E. Drew, Milwaukee	x		
S. A. Morton, Milwaukee			x
N. W. Bourne, Milwaukee	x		
C. M. Echols, Milwaukee	x		
Norbert Enzer, Milwaukee	x		
R. F. Purtell, Milwaukee	x		
J. W. Fons, Milwaukee	x		
J. W. Truitt, Milwaukee	x		
J. D. Steele, Milwaukee	x		
J. S. Allen, Norwalk		x	
R. J. Goggins, Oconto Falls		x	
W. S. Bump, Rhinelander		x	
G. W. Carlson, Appleton		x	
C. E. McJilton, River Falls		x	
L. O. Simenstad, Osceola		x	
E. E. Kidder, Stevens Point		x	

	Yes	No	Not Voting
J. D. Leahy, Park Falls		x	
T. C. Hemmingsen, Racine	x		
George Parke, Sr., Viola		x	
H. E. Kasten, Beloit		x	
L. M. Lundmark, Ladysmith		x	
Roger Cahoon, Baraboo		x	
A. A. Cantwell, Shawano	x		
C. J. Weber, Sheboygan		x	
R. L. MacCornack, Whitehall		x	
J. R. Richter, Chaseburg		x	
E. D. Sorenson, Elkhorn	x		
J. G. Hoffmann, Hartford	x		
H. T. Barnes, Delafield	x		
A. M. Christofferson, Waupaca		x	
G. R. Anderson, Neenah	x		
K. H. Doege, Marshfield		x	
A. W. Bryan, Madison		x	
J. K. Trumbo, Wausau		x	
R. P. Montgomery, Milwaukee	x		
L. V. Littig, Madison		x	
	30	44	1

The question was raised as to one of the properly accredited delegates from Milwaukee County. Secretary Crownhart announced that the proper credential was filed on behalf of Dr. H. R. Foerster and that he was accredited to vote. The total vote was recorded as 44 "No," 30 "Yes," and 1 absent.

Speaker Cary announced that the motion was lost.

Dr. J. W. Fons, Milwaukee, rose to a point of information as to a properly accredited delegate from Dane County, noting that Doctor Leonard of Madison was called, but his name did not appear on the printed list. Secretary Crownhart announced that Doctor Leonard's credentials were submitted to the Credentials Committee, as he had been reported as a delegate in place of Dr. Gorton Ritchie of Madison.

Doctor Trumbo asked that the pending question be read and a roll call vote taken. Speaker Cary asked Secretary Crownhart to state the question, which was stated to be "to amend the original motion of Doctors Doege–Littig by substituting the minority report for the majority report."

This question was discussed by Doctor Purtell; Doctor Vingom, Madison; Doctor Truitt, Milwaukee; and Doctor Fons, Milwaukee. Doctor Drew of Milwaukee arose to a question of privilege, asking that the membership of the committee be polled as to how each member voted. Doctor Gramling seconded the motion. Speaker Cary announced that the request would be granted without vote. By instruction of the Speaker, the secretary polled the committee with the results as follows: Dr. Dexter Witte, Milwaukee, chairman, voted for the minority report. Doctor Fons, Milwaukee, voted for the minority report. Doctor Truitt, Milwaukee, voted for the minority report. Dr. E. M. Dessloch of Prairie du Chien was absent. Dr. Gunnar Gundersen, La Crosse, voted for the majority report. Doctor Littig, Madison, cast his vote for the majority report. Doctor Nadeau, Marinette, voted for the majority report. Doctor Stewart, Kenosha, voted for the majority report, as did Dr. C. O. Vingom of Madison.

Further discussion was entered into by Dr. Dexter Witte, Milwaukee; Dr. C. O. Vingom, Madison; Dr. J. S. Supernaw, Madison; Dr. L. W. Hipke, Milwaukee; Dr. R. L. MacCornack, Whitehall; and Dr. A. H. Heidner, West Bend.

After further discussion the secretary was instructed to call the roll of the House on the motion by Doctor Enzer to amend the original motion by Doctor Doege to substitute the minority report for the majority report. The roll was called and the delegates voted as follows:

	Yes	No	Absent
W. E. Bargholtz		x	
S. O. Lund		x	
O. W. Saunders		x	
A. J. McCarey		x	
A. C. Engel		x	
S. E. Williams		x	
H. H. Christofferson		x	
E. F. Tierney		x	
J. S. Supernaw		x	
F. F. Bowman		x	
N. A. Hill		x	
T. A. Leonard		x	
H. Kent Tenney		x	
F. G. Bachhuber	x		
J. W. McGill		x	
W. R. Manz		x	
D. J. Twohig, Sr.		x	
O. S. Tenley		x	
E. C. Howell		x	
M. W. Stuessy		x	
L. J. Seward		x	
S. B. Marshall		x	
G. E. Eck		x	
C. A. Vogel		x	
W. C. Stewart			x
J. C. Fox		x	
C. E. Zellmer		x	
R. G. Baker		x	
E. C. Cary	x		
H. H. Christensen		x	
J. M. Bell	x		
S. A. Morton	x		
H. J. Gramling			x
E. L. Bernhart	x		
Aaron Yaffe	x		
T. J. Aylward	x		
H. R. Foerster	x		
Joseph Lettenberger	x		
J. J. Gramling, Jr.	x		
W. A. Ryan			x
F. E. Drew	x		
N. W. Bourne	x		
C. M. Echols	x		
Norbert Enzer	x		
R. F. Purtell	x		
J. W. Fons	x		
J. W. Truitt	x		
J. D. Steele	x		
J. S. Allen		x	
R. J. Goggins		x	
W. S. Bump		x	
G. W. Carlson		x	
C. E. McJilton		x	
L. O. Simenstad		x	
E. E. Kidder		x	
J. D. Leahy		x	
T. C. Hemmingsen	x		
George Parke, Sr.		x	
H. E. Kasten		x	
L. M. Lundmark		x	
Roger Cahoon		x	
A. A. Cantwell	x		

	Yes	No	Absent
C. J. Weber		x	
R. L. MacCornack		x	
J. R. Richter		x	
E. D. Sorenson		x	
J. G. Hoffmann		x	
H. T. Barnes	x		
A. M. Christofferson		x	
G. R. Anderson	x		
K. H. Doege		x	
A. W. Bryan		x	
J. K. Trumbo		x	
R. P. Montgomery			x
L. V. Littig		x	
	22	49	4

The secretary announced the tally as 49 voting "No," 22 "Yes," and 4 absent.

Dr. J. K. Trumbo requested a roll call on the original motion adopting the majority report.

Dr. J. W. Truitt of Milwaukee moved to amend the original motion to the following effect: that where the report states that Surgical Care may retain such money that is left over following its termination, that there be substituted for that a sentence reading, "Wisconsin Physicians Service assume all liabilities and assets." Doctor Truitt further incorporated in his motion that Exhibits A, C, D, and E be labeled as specimens to be further studied by the new committee. Doctor Drew seconded the amendment of Doctor Truitt, and the amendment was put to a vote and carried unanimously.

Speaker Cary instructed the secretary to call the roll on the original motion of Doctors Doege–Littig to adopt the majority report of the committee. Roll call was taken and the vote was recorded as follows:

	Yes	No	Absent	Not Voting
W. E. Bargholtz	x			
S. O. Lund	x			
O. W. Saunders	x			
A. J. McCarey	x			
A. C. Engel	x			
S. E. Williams	x			
H. H. Christofferson	x			
E. F. Tierney	x			
J. S. Supernaw	x			
F. F. Bowman	x			
N. A. Hill	x			
T. A. Leonard	x			
H. Kent Tenney	x			
F. G. Bachhuber	x			
J. W. McGill	x			
W. R. Manz	x			
D. J. Twohig, Sr.	x			
O. S. Tenley	x			
E. C. Howell	x			
M. W. Stuessy	x			
L. J. Seward	x			
S. B. Marshall	x			
G. E. Eck	x			
C. A. Vogel	x			
W. C. Stewart			x	
J. C. Fox	x			
C. E. Zellmer	x			
R. G. Baker	x			
E. C. Cary	x			
H. H. Christensen	x			
J. M. Bell	x			
S. A. Morton		x		
H. J. Gramling			x	
E. L. Bernhart			x	
Aaron Yaffe		x		
T. J. Aylward		x		
H. R. Foerster		x		
Joseph Lettenberger		x		
J. J. Gramling, Jr.		x		
W. A. Ryan			x	
F. E. Drew		x		
N. W. Bourne		x		
C. M. Echols		x		
Norbert Enzer		x		
R. F. Purtell				x
J. W. Fons		x		
J. W. Truitt		x		
J. D. Steele		x		
J. S. Allen	x			
R. J. Goggins	x			
W. S. Bump	x			
G. W. Carlson	x			
C. E. McJilton	x			
L. O. Simenstad	x			
E. E. Kidder	x			
J. D. Leahy	x			
T. C. Hemmingsen	x			
George Parke, Sr.			x	
H. E. Kasten	x			
L. M. Lundmark	x			
Roger Cahoon	x			
A. A. Cantwell	x			
C. J. Weber	x			
R. L. MacCornack	x			
J. R. Richter	x			
E. D. Sorenson	x			
J. G. Hoffmann	x			
H. T. Barnes	x			
A. M. Christofferson	x			
G. R. Anderson	x			
K. H. Doege	x			
A. W. Bryan	x			
J. K. Trumbo	x			
R. P. Montgomery		x		
L. V. Littig	x			
	55	14	5	1

Secretary Crownhart announced that there were 55 "Yes," 14 "No," 5 "Absent," and 1 not voting. Speaker Cary announced that the motion was carried.

Chairman Doege then moved that the report of the Reference Committee as acted upon by the House be accepted as a whole. There were various seconds. Doctor MacCornack moved that the motion be so amended as to make the action unanimous. Doctor Barnes seconded the motion. The motion was put to a vote and carried, but not unanimously.

Further Committee Appointments

President-Elect Dawson was called upon by the Speaker to make further committee appointments, which were announced as follows:

To the Council on Medical Service and Public Relations:

Dr. R. G. Arveson, Frederic, chairman—5 years
Dr. J. S. Supernaw, Madison—4 years
Dr. R. P. Montgomery, Milwaukee—3 years
Dr. C. R. Marquardt, Milwaukee—2 years
Dr. A. E. Rector, Appleton—1 year

To the Special Committee of the House to Study the Relationship of Component County Medical Societies to the State Medical Society of Wisconsin

1st	District:	F. A. Gruesen, Fort Atkinson
2d	"	E. D. Sorensen, Elkhorn
3d	"	H. Kent Tenney, Madison, Chairman
4th	"	E. M. Dessloch, Prairie du Chien
5th	"	Arnold Barr, Port Washington
6th	"	F. L. Crikelair, Green Bay
7th	"	J. C. Harman, La Crosse
8th	"	R. J. Goggins, Oconto Falls
9th	"	H. H. Christensen, Wausau
10th	"	C. B. Hatleberg, Chippewa Falls
11th	"	J. W. McGill, Superior
12th	"	J. M. Sullivan, Milwaukee
		C. R. Marquardt, Milwaukee
		Forrester Raine, Milwaukee
13th	"	H. B. Norviel, Phillips

Dr. F. E. Drew of Milwaukee moved that the appointments be approved, seconded by Dr. C. M. Echols, also of Milwaukee, and the motion was carried unanimously.

Speaker Cary presented to the House the new Speaker of the House, Dr. Gunnar Gundersen, La Crosse, and the Vice-Speaker, Dr. A. A. Cantwell of Shawano. Speaker Cary then called upon the secretary for announcements, with the secretary extending his personal appreciation to the members of the office staff who had helped so actively in the preparation of the meeting—extending his appreciation to Mr. Roy T. Ragatz, assistant secretary; Mr. Ralph Weber and Mr. T. J. Doran; Miss Helen Brandt; Mrs. Mary Davis; Miss Margaret Kracht; Mrs. Frances Roberts; Mrs. Alberta Marquardt; Miss Vade Burkhardt; Mrs. Loretta Thompson; Mrs. Lois Rasmussen; and Mrs. Ellen Atkinson.

In addition the secretary stated the assurance of his office that the councilors, office and staff would give their complete cooperation in the development of the Wisconsin Physicians' Service.

Dr. F. E. Drew, Milwaukee, moved that the House adjourn sine die, it was variously seconded, and put to a vote, carried unanimously.

Attendance at House of Delegates, Milwaukee, October 6, 7, 8, 1946

Society	*Delegate*	*Sessions* 1	2	3
Ashland–Bayfield–Iron	C. W. Lockhart, Mellen	a	x	x
	J. W. Prentice, Ashland*	x	x	a
	W. E. Bargholtz, Ashland*	x	x	x
Barron–Washburn–Sawyer–Burnett	S. O. Lund, Cumberland	x	x	x
	O. E. Rydell, Rice Lake*	a	a	a
Brown–Kewaunee–Door	O. W. Saunders, Green Bay	x	x	x
	W. P. Tippet, Green Bay*	a	a	a
	A. J. McCarey, Green Bay	x	x	x
	W. A. Killins, Green Bay*	a	a	a
Calumet	A. C. Engel, New Holstein	x	x	x
	N. J. Knauf, Chilton*	a	a	a
Chippewa	S. E. Williams, Chippewa Falls	x	x	x
	Frank Sazama, Chippewa Falls*	a	a	a
Clark	H. H. Christofferson, Colby	x	x	x
Columbia–Marquette–Adams	E. F. Tierney, Portage	a	x	x
	R. B. D yer, Poynette*	x	x	x
Crawford	G. R. Hammes, Seneca	a	a	a
	E. H. Lechtenberg, Prairie du Chien*	a	a	a
Dane	J. S. Supernaw, Madison	x	a	y
	A. C. Stehr, Madison*	a	a	a
	R. F. Schoenbeck, Stoughton	a	a	a
	F. F. Bowman, Madison*	x	x	x
	N. A. Hill, Madison	x	x	x
	C. G. Reznichek, Madison*	x	a	a
	G. H. Ewell, Madison	x	x	a
	T. A. Leonard, Madison*	x	x	x
	H. Kent Tenney, Madison	x	x	x
	L. R. Cole, Madison*	x	x	x
Dodge	F. G. Bachhuber, Mayville	x	x	x
	E. S. Elliott, Fox Lake*	x	x	a
Douglas	J. W. McGill, Superior	x	x	x
	H. A. Sincock, Superior*	a	a	a
Eau Claire–Dunn–Pepin	W. R. Manz, Eau Claire	x	x	x
	B. F. Johnson, Mondovi*	a	a	a
Fond du Lac	D. J. Twohig, Sr., Fond du Lac	x	x	x
	D. N. Walters, Fond du Lac*	x	x	a
Forest	O. S. Tenley, Wabeno	x	x	x
	G. W. Ison, Crandon*	a	a	a
Grant	E. C. Howell, Fennimore	x	x	x
	J. D. Glynn, Lancaster*	a	x	x
Green	M. W. Stuessy, Brodhead	x	x	x
	F. J. Bongiorno, Albany*	a	a	a
Green Lake–Waushara	L. J. Seward, Berlin	a	x	x
	S. L. Hadden, Wild Rose*	a	a	a

* After name—alternate delegate.
x Present.
a Absent.

Society	Delegate	Sessions 1	2	3
Iowa	S. B. Marshall, Hollandale	x	x	x
	H. M. Walker, Dodgeville*	a	a	a
Jefferson	G. E. Eck, Lake Mills	x	x	x
	O. F. Dierker, Watertown*	x	a	a
Juneau	C. A. Vogel, Elroy	x	x	x
	J. S. Hess, Mauston*	a	a	a
Kenosha	W. C. Stewart, Kenosha	x	x	x
	A. F. Rufflo, Kenosha*	a	a	x
La Crosse	J. C. Fox, La Crosse	x	x	x
Lafayette	H. F. Hoesley, Shullsburg	a	a	a
	L. A. Van Ells, Shullsburg*	a	a	a
Langlade	C. E. Zellmer, Antigo	x	x	x
	W. P. Curran, Antigo*	x	a	a
Lincoln	R. G. Baker, Tomahawk	x	x	x
	K. A. Morris, Merrill*	a	x	x
Manitowoc	E. C. Cary, Reedsville	x	x	x
	G. A. Rau, Manitowoc*	a	a	a
Marathon	E. E. Fleming, Wausau	a	a	a
	H. H. Christiansen, Wausau*	x	x	x
Marinette–Florence	J. M. Bell, Peshtigo	a	x	x
	J. D. Zeratsky, Marinette*	a	x	x
Milwaukee	E. D. Schwade	a	a	a
	J. R. Regan*	a	a	a
	S. A. Morton	x	x	x
	H. J. Gramling*	a	a	x
	M. J. Fox	x	a	x
	E. L. Bernhart*	x	x	x
	M. J. Bach	a	a	a
	D. J. Ansfield*	a	a	a
	Aaron Yaffe	x	x	x
	L. H. Guerin*	x	x	a
	T. J. Aylward	x	x	x
	H. R. Foerster*	x	a	x
	O. A. Sander	x	x	a
	Joseph Lettenberger*	x	x	x
	J. J. Gramling, Jr.	x	x	x
	C. F. McDonald*	a	x	x
	W. A. Ryan	x	x	x
	A. D. Spooner*	a	a	a
	Forrester Raine	x	x	a
	W. J. MacKedon*	x	x	a
	F. E Drew	x	x	x
	N. W Bourne*	x	x	x
	C. M. Echols	x	x	x
	M. W. Sherwood*	x	a	x
	Norbert Enzer	x	x	x
	J. V. Herzog*	x	x	a
	R. F. Purtell	x	x	x
	M. Q. Howard*	x	a	a
	J. W. Fons	x	x	x
	W. J. Houghton*	x	x	a
	J. W. Truitt	x	x	x
	A. I. Rosenberger*	a	a	a
	F. A. Ross	x	x	x
	J. D. Steele*	x	x	x
Monroe	J. S. Allen, Norwalk	x	a	x
	G. C. Devine, Ontario*	a	a	a
Oconto	R. J. Goggins, Oconto Falls	x	x	x
	A. F. Slaney, Oconto*	a	x	x
Oneida–Vilas	W. S. Bump, Rhinelander	x	x	x
	I. E. Schiek, Rhinelander*	a	a	a
Outagamie	G. W. Carlson, Appleton	x	x	x
	J. L. Benton, Appleton*	x	x	x
Pierce–St. Croix	C. E. McJilton, River Falls	x	x	x
	O. H. Epley, New Richmond*	a	a	a
Polk	L. O. Simenstad, Osceola	x	x	x
	V. C. Kremser, Amery*	a	a	a
Portage	E. E. Kidder, Stevens Point	a	a	x
	W. C. Sheehan, Stevens Point*	a	a	a
Price–Taylor	J. D. Leahy, Park Falls	x	x	x
	L. E. Nystrum, Medford*	a	a	a
Racine	T. C. Hemmingsen, Racine	x	x	x
	E. J. Schneller, Racine*	x	a	x
Richland	Geo. Parke, Sr., Viola	a	x	x
	D. J. Taft, Richland Center*	a	a	a
Rock	H. E. Kasten, Beloit	x	x	x
	W. T. Clark, Janesville*	x	x	x
Rusk	L. M. Lundmark, Ladysmith	x	x	x
	Woodruff Smith, Ladysmith*	x	a	a
Sauk	Roger Cahoon, Baraboo	x	x	x
	J. F. Moon, Baraboo*	x	x	x
Shawano	A. A. Cantwell, Shawano	x	x	x
	E. E. McCandless, Birnamwood*	a	a	a
Sheboygan	C. J. Weber, Sheboygan	x	x	x
	P. B. Mason, Sheboygan*	a	x	x
Trempealeau–Jackson–Buffalo	R. L. MacCornack, Whitehall	x	x	x
	Robert Krohn, Black River Falls*	x	x	x

Society	Delegate	Sessions 1	2	3
Vernon	R. S. Hirsch, Viroqua	a	a	a
	F. F. Gollin, LaFarge*	a	a	a
	J. R. Richter, Chaseburg	x	x	x
Walworth	E. D. Sorenson, Elkhorn	x	x	x
	R. A. Mullen, Burlington*	a	a	a
Washington–Ozaukee	J. G. Hoffmann, Hartford	x	x	x
	Arnold Barr, Port Washington*	a	x	x
Waukesha	H. T. Barnes, Delafield	x	x	x
	E. C. Van Valin, Sussex*	x	a	x
Waupaca	A. M. Christofferson, Waupaca	x	x	x
	F. J. Pfeifer, New London*	a	a	a
Winnebago	G. R. Anderson, Neenah	x	x	x
	W. A. Wagner, Oshkosh*	x	a	a
Wood	K. H. Doege, Marshfield	x	a	x
	F. X. Pomainville, Wis. Rapids*	a	x	a
Section on Cardiology	A. W. Bryan, Madison	x	x	x
	F. D. Murphy, Milwaukee*	a	a	a
Section on Ophthalmology and Otolaryngology	J. K. Trumbo, Wausau	x	x	x
	A. H. Pember, Janesville*	a	a	a
Section on Orthopedics	R. P. Montgomery, Milwaukee	x	a	x
	L. D. Smith, Milwaukee*	a	a	a
Section on Radiology	L. V. Littig, Madison	x	x	x
	R. F. Wilson, Beloit*	a	a	a

Physicians in Service

For many months material in this section was carried under the title of "The Nation at War." With physicians still entering service, with many returning to reestablish themselves in civilian practice, and with many planning to continue in service for an indefinite time, it is the decision of the *Journal* to continue the section under a more timely title.

Military Notes

Commander Theodore W. Dasler, former Deer Park practitioner who has been a physician in the Navy since October 1941, has recently been assigned overseas duty in the European Theater.

Commander Dasler has served at the Naval Training Station, Great Lakes, Illinois; the U. S. N. Medical Center, Washington, D. C.; on board the USS Aylwin on the Pacific; at the Naval Hospital and Hospital Corps School at Farragut, Idaho; with the USS Huntington Commissioning Detail, Newport, Rhode Island; and on board the USS Huntington (CL–107). He is a wearer of the American Theater and Asiatic–Pacific Theater ribbons.

Medical Consultants of World War II Hold Conclave at Walter Reed Hospital

Major General Norman T. Kirk, Surgeon General, United States Army, and Brigadier General George C. Beach, Jr., Commanding General, Army Medical Center and Walter Reed General Hospital, were hosts to the first formal meeting of the Society of United States Medical Consultants of World War II, which was held in Sternberg Auditorium at the Army Medical Center, Washington, D. C., October 18. **Dr. William S. Middleton**, dean of the University of Wisconsin Medical School was one of the medical consultants present at the meeting.

The Society is composed of the doctors, formerly medical officers and now returned to civilian life, who were consultants for the Army Medical Department in The Surgeon General's Office, in overseas theaters and in the Zone of Interior during the war. They represent the leading men in specialized fields.

The group has formed this association under its own initiative and with the purpose of furthering the advance of the medical profession in the United States, with the particular objective of establishing a close liaison with Army medicine. Its plans are in the formative stage as yet and one aim of this meeting was to set up a working mode of procedure which will enable them to carry out their objectives.

The meeting was opened by an address by the president of the Society, former Brigadier General Elliott C. Cutler, now of Harvard University. This was followed by a talk by Major General Norman T. Kirk who paid tribute to the men whom he considers to have been highly instrumental in the record established by the Medical Department during the war, with its outstandingly low death and disease rate, stating "I am most grateful that this organization has been formed. I am sure that you

(Continued on page 1199)

POSTWAR QUESTIONNAIRE

Prepared by the
NATIONAL EMERGENCY MEDICAL SERVICE COMMITTEE
of the
AMERICAN MEDICAL ASSOCIATION
535 North Dearborn Street, Chicago 10, Illinois

GENERAL INFORMATION

6-9. Graduate of_____ (Exact name of medical school) 10-11. Graduation_____ (Year)

12-13. Year of birth_____ 14-17. DATES: Entered military service _____ (Month) _____ (Year) and Discharge _____ (Month) _____ (Year)

18-20. At time of entering active military service you were in:

☐ Full General Practice ☐ Practice limited Exclusively to Specialty checked (V) below ☐ General Practice with Special Attention devoted to the ONE Specialty checked (V) below ☐ Residency of type checked (V) below ☐ Internship

21-22.

☐ 1. Surgery	☐ 12. Ophthalmology	☐ 23. Pathology
☐ 2. Neurological Surgery	☐ 13. Otolaryngology	☐ 24. Clinical Pathology
☐ 3. Plastic Surgery	☐ 14. Ophthalmology—Otolaryngology	☐ 25. Bacteriology
☐ 4. Industrial Practice	☐ 15. Pediatrics	☐ 26. Public Health
☐ 5. Obstetrics	☐ 16. Neurology	☐ 27. Allergy
☐ 6. Gynecology	☐ 17. Psychiatry	☐ 28. Cardiology
☐ 7. Obstetrics and Gynecology	☐ 18. Neurology and Psychiatry	☐ 29. Gastroenterology
☐ 8. Orthopedic Surgery	☐ 19. Internal Medicine	☐ 30. Physical Medicine
☐ 9. Proctology	☐ 20. Tuberculosis	☐ 31. Thoracic Surgery
☐ 10. Urology	☐ 21. Anesthesia	☐ 32. _____ (Other)
☐ 11. Dermatology	☐ 22. Roentgenology, Radiology	

23-24. If a Specialist, do you hold a certificate from any of the following American Boards?

Yes ☐ No ☐ If Yes, indicate which Board by (V) Year received_____

☐ 1. Pediatrics	☐ 6. Urology	☐ 11. Otolaryngology
☐ 2. Psychiatry and Neurology	☐ 7. Obstetrics and Gynecology	☐ 12. Surgery
☐ 3. Orthopaedic Surgery	☐ 8. Internal Medicine	☐ 13. Anesthesiology
☐ 4. Dermatology and Syphilology	☐ 9. Pathology	☐ 14. Plastic Surgery
☐ 5. Radiology	☐ 10. Ophthalmology	☐ 15. Neurological Surgery

25. Circle years of active service in the armed forces since 1939: 1 2 3 4 5 6 7

26. Your military service was with: ☐ Army (1) ☐ Navy (2) ☐ USPHS (3) ☐ VA (4) ☐ Other (explain) (5)_____

27. Highest military rank_____

28-47. Name of region and months of service there:

	Months		Months		Months
1. N. America (Entire Continent, including Alaska and Aleutians, Canada, Central America, Panama, etc.)		5. Africa (Entire Continent)		9. South Pacific	
2. S. America (Entire Continent)		6. China, Burma, India		10. Japan (Korea)	
3. Br. Isles		7. Atlantic (West Indies, Iceland, etc.)		11. Other	
4. Europe (Including Mediterranean)		8. Central Pacific			

48. Circle months of service outside U. S. A.: None 6 12 18 24 30 36 42 48 54 or more

MILITARY SERVICE

49-78. Nature of services, areas (write-in numbers 1 to 11 for areas as listed in Question 28-47 above) and duration:

N. B.—List **ALL** services and areas in which you served, even though the same (period of) months may be recorded more than once.

	Areas (Use numbers)	Months		Areas (Use numbers)	Months
49-51. Hospitals			70-72. Training of others		
52-54. Dispensaries			73-75. Administration [Not (medical) Commanding Officer]		
55-57. Tactical Units			OR		
58-60. Troopship, L. S. T., etc.			76-80. You were (medical) Commanding Officer (e. g. Hospital, Battalion, Ship, etc.)		
61-63. Battleship or Cruiser					
64-66. Smaller Ships, Destroyer, etc.				_____ (Specify Unit)	
67-69. Shore Installations					

OVER

During COMBAT or NONCOMBAT service what proportion of a full day's work (by civilian standards) was, on the average, actually needed to perform the duties of your assignment?

106 Combat (circle percentage) 20% 40% 50% 60% 80% 100% 110% 120% 150% _____%

107 Noncombat: (circle percentage) 20% 40% 50% 60% 80% 100% 110% 120% 150% _____%

108. What percentage of the doctors assigned to your unit were, in your opinion, actually needed:_____

109 What percentage of your time was devoted to nonprofessional duties?_____

110-114. Describe these nonprofessional duties:_____

115-122. Check (V) types of personnel that could have performed these nonprofessional duties:

115. ☐ MAC 116. ☐ Hosp. Corps. 117. ☐ First Aid 118. ☐ Clerks 119. ☐ Nurses 120. ☐ Other_____

TRAINING

123-128. Check (V) features of training you considered most useful:

123. ☐ Basic 125. ☐ Professional on the job 127. ☐ Tactical

124. ☐ Unit 126. ☐ Service School 128. ☐ _____ (Write in other features)

129-132. What important features of training were not sufficiently stressed?_____

133-137. What in your opinion should be included in an ideal training program?_____

ASSIGNMENTS

138. Rate the method of assignment you encountered: ☐ Good 1 ☐ Fair 2 ☐ Poor 3

Comments: _____

139. Were you rotated in your assignment? ☐ Yes ☐ No

140-142. If there was waste of medical personnel in your unit, please state how personnel could have been used more effectively._____

143-148. What suggestions have you about method of assignment of medical officers in the event of another military emergency?_____

PROFESSIONAL SKILLS

149. To what extent was effort made to utilize your professional skills: ☐ Considerable 1 ☐ Some 2 ☐ Very Little 3 ☐ None 4

150-158. Did you regularly receive: 150. ☐ AMA Journal 151. ☐ State Journals 152. ☐ Specialty Journals 153. ☐ Technical Bulletins 154. ☐ BUMEDS 155. ☐ Theatre News 156. ☐ Bulletins 157. ☐ Army Medical Bulletin 158. County Medical Society Bulletins

159. Were there teaching clinics in your theatre? ☐ Yes ☐ No

160. Were there medical meetings in your theatre? ☐ Yes ☐ No

161-173. What suggestions do you have for helping the doctor in service to keep up professionally?

- ☐ Prompt receipt of latest literature
- ☐ Surgical demonstrations
- ☐ Hospital assignment
- ☐ Refresher courses
- ☐ Medical movies
- ☐ Lectures
- ☐ Assignments better fitted to professional skills
- ☐ Frequent review of your qualifications
- ☐ Medical (non-military) staff meetings
- ☐ Library facilities
- ☐ Other suggestions_____

ADDITIONAL REMARKS

If this space is insufficient to record your ideas, please attach your letter hereto.

(Optional) Signature

_____

Address _____

☞ OVER

(Continued from page 1196)

can be as much help in peace as during the war in assisting the Medical Department of the Army to get the necessary things done, and to be prepared, if another war comes, to carry out the job."

Dr. Eli Ginzberg, former chief of resources analysis, Office of The Surgeon General, and now professor of economics at Columbia University, gave an analysis of the problems of the Medical Department during the war, the various methods tried, and those which proved successful. He called particular attention to the achievements of the Medical Regulating Officer, through whose offices flowed the assignment of patients at the rate of 2,000 per day who were sent to hospitals according to their type of injury or disease, their home address, and various other factors which were taken into consideration in each individual case.

Major General W. S. Paul, director of personnel administration, G-1, described the revised organization chart of the Army explaining how it cleared out many barriers to enable the Technical Services to function at an optimum.

Comments and questions were freely asked and made from the floor by about 90 consultants who had travelled from points throughout the United States. Luncheon was followed by a closed afternoon session attended only by members, for the discussion and ratification of the constitution and other business matters. During the election of officers, **Dr. William S. Middleton** was chosen one of the members of a committee of four Councellors.

Returning Veterans

Milwaukee physician, **Lieutenant Walter W. Busby** resumed his civilian practice after receiving a discharge from the Navy June 17. Entering military service August 23, 1943, the doctor was stationed first at the U. S. Naval Hospital at San Diego, California. In November 1943 he was sent to Pensacola, Florida, to attend the School of Aviation Medicine and Flight Training for four months before reporting for sea duty. Returning to this country in November 1944, Lieutenant Busby served at the N. A. S. Dispensary in Norfolk, Virginia, and at Navy Pier, Chicago, before he was separated from the armed forces.

He is a wearer of the North African Theater ribbon.

Lieutenant Commander Donald W. Calvy of Fond du Lac, who started active duty with the Navy September 1, 1942, was discharged March 22, 1946, and is now a resident in urology at the U. S. Veterans Hospital at Wood.

During his three and one-half years in military service, Commander Calvy served at the following stations: Naval Hospital, San Diego, California; on board the USS Rathburne (DD 113) in the Pacific; Marine Corps Air Station, El Toro, California; Marine Corps Air Depot, Miramar, California; Naval School of Aviation Medicine, Pensacola, Florida; Office of Naval Officer Procurement, San Francisco; and Naval Air Base #824, Kwajalein, Marshall Islands. Commander Calvy is entitled to wear the American and Asiatic Theater ribbons.

Captain Gabriel E. Ceci was discharged from the Army June 1, and a month later began his civilian practice of medicine in Milwaukee. While in service, Captain Ceci did general medical work at Fort Leavenworth, Kansas, until transferred to the Veterans Hospital at Des Moines, Iowa, where he was ward surgeon in charge of women veterans. In March 1946 the doctor was assigned duty at the Veterans Hospital at Wood, Wisconsin, serving there until he received his release from active duty.

After serving for two and one-half years in the Navy, including eleven months of overseas duty, **Lieutenant Commander William B. Hildebrand** has returned to his civilian practice in Menasha. He entered the Navy October 25, 1943 and was discharged May 23, 1946.

Commander Hildebrand's first military assignment was Naval Training Station, San Diego, California. Later he served at the Naval Air Station, San Clemento Island, California; Naval Air Station, Pensacola, Florida; and Marine Corps Air Station, El Toro, California, before reporting for overseas duty. In the Pacific Theater, the doctor was stationed with Marine Air Group 11 at Peleliu in the Caroline Islands; with Marine Air Group 22 on Ie Shima, Ryukyu Islands; Marine Air Group 14 on Okinawa, Ryukyus; and with a Marine air group at Honolulu, Hawaii. Returning to this country in April 1946, he reported to the Naval Training Station at Great Lakes for a month.

Commander Hildebrand is a wearer of the American and Asiatic–Pacific Theater ribbons and the Victory Medal. He was awarded the Presidential Unit Citation with one star, and stars for the battles of Iwo Jima and Okinawa.

Captain Henry J. Katz resumed his civilian practice in Cedarburg after receiving an Army discharge at Fort Logan, Colorado, in March. His terminal leave expired April 10. The doctor entered the Army after completing his internship at St. Joseph's Hospital in Milwaukee in 1944. He served, among other places, in Italy and at the U. S. General Hospital, Camp Carson, Colorado.

Lieutenant Colonel Harold Nebel, Milwaukee, was discharged from the Army March 31 after five and

one-half years of active military service, and returned to his Milwaukee civilian practice.

Colonel Nebel served from October 15, 1940 to August of 1942 with the 121st Field Artillery, 32d Division, at Camp Livingston, Louisiana. He was then transferred to the IV Armored Corps Headquarters, Desert Training Center, California. The doctor served with this corps, which became the XX Corps of the Third Army, at Camp Campbell, Kentucky, and in the European Theater until he was discharged.

Colonel Nebel is entitled to wear the American Defense, American Theater, and African–Middle Eastern Theater ribbons, and has star awards for the Normandy, Northern France, and Rhineland campaigns. He was also awarded the French Medal of Verdun and the French Medal of Metz.

Dr. Eugene J. Nordby, Madison, who served as orthopedic surgeon in the Army Medical Corps in this country and overseas, was separated from the service recently and has become associated in practice with **Dr. Henry L. Greene** in Madison.

During his two years of active military duty, started October 6, 1944, Doctor Nordby served at Carlisle Barracks, Pennsylvania; Jackson, North Carolina; and Fort Lewis, Washington. Overseas he rendered service at Okinawa and as chief of the orthopedic sections in hospitals in Seoul and Pusan, Korea.

Former Siren physician, **Lieutenant Lloyd F. Sherman**, was released from active duty with the armed forces March 4, after serving in the Navy since June 15, 1943. He is now on a fellowship in the department of surgery at Veterans Hospital, Minneapolis.

While in the Navy the doctor served at the following stations: Naval Hospital, Great Lakes, Illinois; Midshipmen's School, Northwestern University, Chicago; and Marine Field Medical School, Camp Elliot, California. Overseas he saw action in the field with the 1st Marine Division, Pacific Theater, for almost two years. The doctor wears the Pacific Theater ribbon with three combat stars, and was awarded the Commanding General's citation for Okinawa.

After an absence of over two and one-half years, **Major Edgar A. Weller** has returned to Weyauwega to resume his civilian medical practice. Major Weller entered the Army December 16, 1943 and was discharged August 5, 1946.

He was on active duty at Carlisle Barracks, Pennsylvania; O'Reilly General Hospital, Springfield, Missouri; and Station Hospital, Fort Leavenworth, Kansas, before reporting for overseas assignments. In the European Theater he served with the 116, 197, and 178 General Hospitals, the 77 Evacuation Hospital Advance Section Medical, and the 550 F. A. Battalion. Upon his return to the United States the doctor was assigned to Regional Hospital, Camp Swift, Texas, and then Headquarters Separation Center, Camp McCoy, Wisconsin. He is entitled to wear the European–African–Middle Eastern and American Theater ribbons and the ribbon for the Army of Occupation. He was awarded the Bronze Star and a battle star for the Rhineland campaign.

C. P. HASELTINE

After four years of active military duty, **Lieutenant Commander Charles P. Haseltine** of Ripon was separated from the Navy August 8.

Training for a few weeks at Great Lakes, Illinois, Commander Haseltine was then assigned to the USS Tennessee, serving almost two years in the Pacific area — in the Aleutians, Marshalls, Marianas, Gilberts, and other islands, among them Kwajalein, Tarawa, and Eniwetok. Returning to this country in June 1944, he was stationed at the Naval Air Training Station, Pensacola, Florida, and the Marine Corps Air Station at Cherry Point, North Carolina, until December 1944. Transferred overseas again in February of 1945, the doctor was on duty with Marine Air Groups at Oahu, Hawaii, Tsingtao and Peping, China.

Commander Haseltine is a wearer of the American and Asiatic–Pacific (with three battle stars) Theater ribbons, and holds the Navy Unit Commendation Award.

Recent Releases From Service*

Physicians and Locations	Date Discharged
Armbruster, J. L., Milwaukee	June, 1946
Baier, A. R., Oshkosh	July, 1946
Belfus, F. H., Milwaukee	April, 1946
Bill, K. C., Palmyra	December, 1946
Boerner, H. F., Jr., Milwaukee	October, 1946
Busby, W. W., Milwaukee	June, 1946
Cash, I. I., Milwaukee	October, 1946
Danforth, H. J., Oshkosh	July, 1946
Dunker, G. O., Milwaukee	March, 1946
Edelstein, R. B., Racine	June, 1946
Fabric, B. L., Milwaukee	June, 1946
Gaunt, J. J., Milwaukee	May, 1946
Haman, K. L., New London	September, 1946
Haseltine, C. P, Ripon	August, 1946
Hoessel, A. W., Oshkosh	August, 1946
Kores, A. B., Beaver Dam	August, 1946
Lynch, J. D., Hines, Illinois	January, 1946
McCarty, Robert, Milwaukee	April, 1946
Miller, G. E., Marshfield	May, 1946

* Members of the State Society listed in bold face.

Physicians and Locations	Date Discharged
Miller, J. E., Madison	December, 1945
Morrison, D. A. R., Oconomowoc	February, 1946
Nebel, Harold, Milwaukee	March, 1946
Schneider, C. R., Milwaukee	April, 1946
Sverdlin, A. A., Milwaukee	June, 1946
Temple, J. W., Fond du Lac	June, 1946
Weller, E. A., Weyauwega	August, 1946
Wright, H. H., Milwaukee	June, 1946

RECENT WISCONSIN LICENTIATES

The following physicians were licensed by the Wisconsin State Board of Medical Examiners at various meetings held this year, but have not been previously reported.

Name	*School of Graduation*	*Year*	*Address*
Aldrich, Clarence K.	Northwestern	1940	Department of Student Health, Wisconsin General Hospital, Madison
Baehr, Louis T.	Wisconsin	1943	510 North Street, Janesville
Bresnahan, John F.	Pennsylvania	1910	Veterans Administration, Wood
Creighton, Louis H.	Temple	1943	811 Sixtieth Street, Kenosha
Drescher, Aubrey A.	Wisconsin	1943	Fennimore
Epley, Verne C.	Oklahoma	1942	131 South Michigan, Prairie du Chien
Fitzgerald, Gerald P.	Loyola	1938	103 West College Avenue, Appleton
Flanagan, Clair M.	Wisconsin	1943	415 West Park Avenue, Waukesha
Foeste, Arthur A.	Wisconsin	1945	3334 Lake Mendota Drive, Madison
Foster, Thomas D.	George Washington	1944	Cornell
Gilmore, William E.	Wisconsin	1943	1300 University Avenue, Madison
Grant, Arthur B.	Marquette	1942	1422 Deane Boulevard, Racine
Hering, George V.	Minnesota	1944	Shell Lake
Hoff, Allan Dale	Wisconsin	1945	East Broadway, Viroqua
Holland, Homer J.	Wisconsin	1943	526 Wisconsin Street, Berlin
Lillie, Richard H.	Harvard	1943	University Hospital, Ann Arbor, Michigan
Link, Joseph K.	Marquette	1941	153 Roberta Avenue, Waukesha
Moss, Kenneth J.	Illinois	1942	2431 Hall Avenue, Marinette
Nester, Hansford D.	Maryland	1936	Midelfart Clinic, Eau Claire
Rink, Richard A.	Northwestern	1942	642½ Pine Street, Burlington
Roisum, Bryant H.	Wisconsin	1945	525 East Mifflin Street, Madison
Siegel, Morris	Illinois	1941	7449 Cottage Grove Avenue, Chicago
Sohrweide, Anton	Emory	1931	1203 Third Street, Watertown
Steffan, Lloyd J.	George Washington	1944	New Holstein
Stoltz, Robert C.	Marquette	1945	Glidden
Tabrah, Frank L.	Buffalo	1943	Black River Falls
Tarrasch, Hertha	Woman's Medical College of Pa.	1941	Institute for Juvenile Research, Chicago
Troubalos, Stephen	Marquette	1943	Louisville, Colorado
Weisse, Harris A.	George Washington	1944	New Holstein

At a meeting held in Milwaukee on October 6 and 7, the Wisconsin State Board of Medical Examiners licensed through reciprocity the following physicians in the practice of medicine after they had successfully passed an examination.

Name	*School of Graduation*	*Year*	*Address*
Burski, Chester C.	Loyola	1940	2740 North Washtenaw Avenue, Chicago
Cassidy, Robert H.	Ohio	1940	Columbia Hospital, Milwaukee
Desulis, B. A.	Illinois	1938	1220 State Street, Beardstown, Illinois
Dwyer, Andrew H.	Wisconsin	1941	1300 University Avenue, Madison
Flanagan, Francis J.	Marquette	1943	524 East North Street, Appleton
Fostvedt, Gerald	Rush	1942	Barron
Frey, William Burton	Minnesota	1943	Milwaukee County Hospital, Milwaukee
Friedman, Morris S.	Rush	1938	30 North Michigan Avenue, Chicago
Headlee, Charles R.	Indiana	1944	144 West Broadway, Milwaukee
Hornberger, Evans Z., Jr.	Nebraska	1942	Columbia Hospital, Milwaukee
Johnson, Richard L.	California	1942	Milwaukee County Hospital, Milwaukee
Johnson, Sture A. M.	Oregon	1938	1300 University Avenue, Madison
Juska, Aldona Ann	Illinois	1940	224 West Washington Avenue, Madison
Karol, Herbert J.	Illinois	1942	6930 Paxton Avenue, Chicago
Keating, Daniel R.	Cornell	1942	857 East Lake Forest Avenue, Milwaukee
Klaas, Frederick B.	Marquette	1943	1472 North Franklin, Milwaukee
Klein, Samuel	Illinois	1942	Milwaukee County Hospital, Milwaukee
McGaughey, Clark G.	Michigan	1943	419 Pleasant Street, Beloit
Manson, Almon A.	Northwestern	1943	Milwaukee County Gen. Hospital, Milwaukee
Maximov, Nicholas	California	1940	1300 University, Avenue, Madison
Mendenhall, John T.	Harvard	1939	1300 University Avenue, Madison
Morris, Lucien E.	Western Reserve	1943	1300 University Avenue, Madison

Name	School of Graduation	Year	Address
Mueller, John J.	Iowa	1936	130 South Twenty-Second Street, La Crosse
Nathan, Alvin	Cincinnati	1944	Milwaukee County Hospital, Milwaukee
Niebauer, Walter E.	Wisconsin	1943	Phillips
Paul, John R., Jr.	South Carolina	1942	1300 University Avenue, Madison
Pelant, K. F.	Marquette	1943	8118 Currie Avenue, Wauwatosa
Pobanz, Sam	Indiana	1944	296 Maple, Elmhurst, Illinois
Santer, Daniel	Washington	1943	Milwaukee County Hospital, Milwaukee
Schuster, Daniel B.	Wisconsin	1943	1532 Church Street, Wauwatosa
Simmons, Warren K.	Chicago	1938	St. Luke's Hospital, Chicago
Snyder, Rufus A.	St. Louis	1936	Gundersen Clinic, La Crosse
Sundeen, Reinhold	Michigan	1942	Swedish Covenant Hospital, Chicago
Yazujian, Levon D.	Louisville	1944	1300 University Avenue, Madison
Yordy, Frank S.	Wisconsin	1943	Wiley-Smith Clinic, Fond du Lac

News Items and Personals

Postgraduate Course in Thoracic Diseases March 3-8, 1947, Madison, Wisconsin

A postgraduate course in thoracic diseases, sponsored by the American Trudeau Society in cooperation with the University of Wisconsin Medical School will be held in Madison, March 3 to 8, 1947.

The intensive course, arranged by the Committee on Postgraduate Medical Education of the American Trudeau Society is designed primarily for physicians of Ohio, Indiana, Michigan, Illinois, Wisconsin, Missouri, Iowa, and Minnesota. With a maximal registration of thirty, applications will be considered first from physicians of those states. Doctors who desire to attend the course may make application to Cameron St. C. Guild, M. D., executive secretary, American Trudeau Society, 1790 Broadway, New York 19, New York, requesting application blanks.

The fee for the course is $50 with at least half of the registration fee to be paid at the time of application. Checks should be made payable to The American Trudeau Society. Hotel accommodations have been reserved for physicians enrolled in the course.

Dr. H. McLeod Riggins, associate in medicine, College of Physicians and Surgeons, Columbia University, will be the moderator, and *Dr. Llewellyn R. Cole*, professor of clinical medicine and coordinator of graduate medical education, University of Wisconsin Medical School will be the director of the course. Visiting faculty and faculty members of the University of Wisconsin Medical School in Madison will be the speakers of the six-day course, the outline of which follows:

OUTLINE OF COURSE

Monday, March 3, 1947

Morning Session

8:00– 9:00 Registration and Welcome
State of Wisconsin General Hospital
Dr. William S. Middleton, dean of the Medical School
Dr. Llewellyn R. Cole, coordinator of graduate medical education
Dr. H. McLeod Riggins, president, American Trudeau Society

9:00–10:00 Anatomy of the Thorax
Dr. W. E. Sullivan, professor of anatomy

10:00–11:00 Physiology of the Cardio-Respiratory System
Dr. W. J. Meek, professor of physiology and associate dean of the Medical School and Dr. R. C. Herrin, professor of physiology

11:00–12:00 Biochemical Aspects of Thoracic Disease
Dr. P. P. Cohen, associate professor of physiological chemistry

Afternoon Session

1:30– 4:30 Pathology of Pulmonary Disease
Dr. Esmond R. Long, professor of pathology, University of Pennsylvania School of Medicine; director, Henry Phipps Institute and *Dr. D. M. Angevine*, professor of pathology

Evening Session

6:30 Dinner Meeting
Doctor Middleton, presiding
"Tuberculosis Problems in War and Peace"
Doctor Long

Tuesday, March 4th

Morning Session

8:00–10:00 Section 1: Medical Ward Rounds
Dr. H. A. Dickie, associate professor of clinical medicine, and *Dr. J. M. Wilkie*, instructor in medicine
Section 2: Surgical Demonstrations
Dr. J. W. Gale, professor of surgery, and *Dr. A. R. Curreri*, associate professor of surgery

10:00–12:00 Clinical Tuberculosis
Doctors Dickie and Wilkie

Afternoon Session

1:30– 3:30 Laboratory Methods
Dr. W. D. Stovall, director, State Laboratory of Hygiene; professor of hygiene
Dr. E. A. Birge, assistant professor of clinical pathology
Dr. W. H. Jaeschke, assistant professor of clinical pathology

3:30– 4:15 Coccidioidomycosis
Dr. G. C. Owen, clinical instructor in medicine, Marquette University School of Medicine

4:15– 5:00 Mycotic Pulmonary Disease
Dr. F. J. Pohle, associate professor of medicine

Wednesday, March 5th

Morning Session

8:00– 9:00 The Diagnosis of Thoracic Tumors
Doctor Middleton

9:00–10:00 The Surgical Treatment of Thoracic Tumors
Doctor Curreri

11:00–12:00 The Surgical Treatment of Suppurative Disease of the Thorax
Doctor Gale

Afternoon Session

1:30– 3:30 Streptomycin in Thoracic Disease
Dr. H. Corwin Hinshaw, consultant in medicine, Mayo Clinic; associate professor in medicine, Mayo Foundation, University of Minnesota Medical School

3:30– 4:30 Present Therapeutic Methods in Acute Pulmonary Disease
Dr. O. O. Meyer, professor of medicine

Evening Session

7:00– 9:00 Anesthesiology
Dr. R. M. Waters, professor of anesthesia, and *Dr. C. P. Wangeman*, assistant professor of anesthesia

Thursday, March 6th

Morning Session

8:00–10:00 Section 1: Surgical Demonstrations
Section 2: Medical Ward Rounds

10:00–12:00 Effects of Thoracic Disease on the Circulatory System
Dr. C. M. Kurtz, associate professor of clinical medicine, and *Dr. H. H. Shapiro*, assistant professor of clinical medicine

Afternoon Session

12:30– 5:00 Lunch at Lake View Sanatorium, followed by Therapy Demonstration of "Pembine" Type. Cases to be presented by *Dr. J. K. Shumate*, superintendent of the sanatorium. Discussion by Consultants and class.

Friday, March 7th

Morning Session

8:00–12:00 Symposium on Tuberculosis Control
Leader: Dr. L. J. Weber, assistant chief, Tuberculosis Control Division, U. S. Public Health Service

Afternoon Session

1:30– 4:30 Discussion and Demonstration of Recent Developments in Mass Radiography
Dr. D. M. Gould, medical officer in charge of radiology, Tuberculosis Control Division, U. S. P. H. S.

Evening Session

6:30– 7:30 The Practical Application of Respiratory Function Tests
Doctor Riggins

7:30– 8:30 Silicotuberculosis
Dr. O. A. Sander, Milwaukee, consultant in industrial pulmonary diseases

8:30– 9:30 Problems of Workmen's Compensation in Thoracic Diseases
Mr. H. A. Nelson, LL. B., director of Workmen's Compensation, Wisconsin Industrial Commission

Saturday, Marc 8th

Morning Session

8:00– 9:00 Tuberculosis in Children
Dr. J. E. Gonce, professor of pediatrics

9:00–10:00 Allergic Bronchial and Pulmonary Disease
Dr. W. A. Mowry, clinical professor of medicine

10:00–11:00 Roentgenologic Diagnosis of the Diseases of the Thorax
Dr. L. W. Paul, professor of radiology

11:00–12:00 Round-Table Discussion of Questions Presented by Class
Medical Leader: Doctor Riggins
Surgical Leader: *Dr. J. D. Steele*, assistant clinical professor of surgery, Marquette University School of Medicine

—△—

The Flying Doctor of Richland Center

B. I. PIPPIN

Dr. B. I. Pippin, Richland Center physician who believes that flying is less dangerous than driving an automobile, estimates that he has saved six months time in the twenty-four years he has been attending conventions and visiting patients by plane.

The doctor, who has been flying planes since 1922 and making professional trips since 1926, flies regularly to Reedsburg to do surgery at the Municipal Hospital. He has owned several different types of planes including a glider and a small seaplane, and has flown to medical conventions in cities all over the country including Boston, Washington, New Orleans, Los Angeles, Miami, and Denver, and even to a convention in Cuba.

In 1926 the Civil Aeronautics Administration was formed and Doctor Pippin was appointed medical aeronautics examiner. He still holds that government position.

—△—

Doctor Andrews Accepts Florida College Post

Dr. M. P. Andrews, eye, ear, nose and throat specialist in Manitowoc for twenty-seven years, left that city in November to take a position as resident physician at the Florida State College for Women at Tallahassee. Doctor Andrews will alse serve 1,000 veterans stationed at an air field near the college. The doctor's son, Dr. Edson Andrews is an eye, ear, and nose specialist in Tallahassee.

—△—

Dr. L. W. Moody is Guest Speaker

Superintendent of Pureair Sanatorium, Bayfield, *Dr. L. W. Moody* was the guest speaker at the regular monthly meeting of the Bayfield Civic League, October 14, in the public library of that city.

Glenwood City Has New Doctor

Dr. Philip W. Limberg of Plymouth, moved to Glenwood City in October to begin a practice in that community. He occupied the offices vacated by *Dr. R. C. Love* several years ago. Doctor Limberg, a veteran of twenty-two months service overseas with the Army during the war, had completed a year as surgical resident physician at Evangelical Deaconess Hospital in Milwaukee, before he located in Glenwood City.

—△—

Doctor Dodd Attends Convention

Dr. J. M. Dodd of Ashland, who celebrated his eightieth birthday early in October, returned the later part of that month from a trip to Waynesburg, Pennsylvania, and Cleveland, Ohio. The doctor visited with old friends in Waynesburg, his birthplace that he left sixty years ago. In Cleveland he attended the convention of the Interstate Post Graduate Medical Association of which he is a trustee.

—△—

Kaukauna Physician Speaks on Polio

Dr. Simon Cherkasky, Kaukauna physician and surgeon, discussed infantile paralysis at a meeting of the Nicolet Parent Teachers Association November 5 at the Nicolet school. The movie, "Your Fight Against Infantile Paralysis," supplied by the State Board of Health, was shown with the talk. Doctor Cherkasky started his practice in Kaukauna September 1 after receiving a discharge from the Army in which he served three years.

—△—

Doctor Bertolaet Retires From Private Practice

Dr. E. E. Bertolaet of Palmyra recently retired from private practice and on November 4 assumed the duties of a position with the State Board of Health. The doctor, who had practiced in Palmyra for about fourteen years, served as health officer of the community for many years.

—△—

Doctors Kearns and Stang Chosen Board Members

At the first postwar meeting of the north central section of the American Urological Association in Rochester, Minnesota, the first part of November, *Dr. Walter M. Kearns* of Milwaukee and *Dr. H. M. Stang* of Eau Claire were named to the executive board of the section. Doctor Kearns is the retiring president.

—△—

Public Health Specialist is Speaker

Dr. Charles K. Kincaid, medical director of the Eau Claire city-county health department, was one of the speakers on the program at the annual state convention of the Wisconsin League of Municipalities held at Fond du Lac, October 17 and 18. He discussed the city-county health unit program.

Two Surgeons Awarded Fellowships

J. W. McROBERTS

At the annual convocation of the International College of Surgeons in Detroit, October 22, *Drs. Jerry W. McRoberts* of Sheboygan and *Harold R. Fehland* of Wausau received Fellowships in the College.

—△—

Doctor Gebhard Speaks at Chicago Meeting

Dr. Urban E. Gebhard of Milwaukee addressed members of the Chicago Society of Industrial Medicine and Surgery at the fall scientific meeting of the society, November 18 in the Palmer House, Chicago. Doctor Gebhard's speech, "Management of Some Common Industrial Accidents," was followed by discussion by Drs. Karl G. Rundstrom, John V. Walker, and J. Daniel Willems of Chicago.

—△—

Dr. P. E. Pifer Passes Fellowship Tests

Dr. Paul E. Pifer of Kenosha was among the thirty-one physicians who passed both the oral and written examinations for Fellowship in the American College of Chest Physicians. The examinations conducted by the College were held in San Francisco June 29.

—△—

Dr. B. R. Walske Leaves Arcadia

Dr. Benedict R. Walske closed his office in Arcadia November 2 and left that community to accept an appointment as chief of surgical service at the Veterans Administration hospital in Marion, Indiana. Doctor Walske began his Arcadia practice in February after separation from the armed forces.

—△—

CORRECTION

An error was made in the news item headed "Golf Tournament" on page 1080 of the November issue of the *Journal.* The second paragraph should read, "The summer (not Summit) tournament will be held in Fond du Lac with *Dr. J. C. Devine* of Fond du Lac in charge of arrangements."

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Menomonee Falls Physician Practices 50 Years

E. W. BURKHARDT

Menomonee Falls physician, *Dr. Edward W. Burkhardt*, 79, completed fifty years of medical practice December 7. He is still in practice, taking care of his office and making his professional calls.

A native of Lindon, Sheboygan County, the doctor taught for two years in a country school near Sheboygan Falls and studied pharmacy before deciding on a career in medicine. After graduation from the Homeopathic Medical College of Missouri in St. Louis in 1896, he practiced in Appleton for seven months before taking over Dr. Allen S. Barndt's practice in Menomonee Falls, where he has remained ever since.

A general practitioner, he serves the area around Menomonee Falls and has driven over 700,000 miles on calls. Doctor Burkhardt estimates that in his fifty years of practice he has delivered over 5,000 babies. For the past several years he has been health officer of Menomonee Falls.

The doctor is a member of many societies including the Waukesha County Medical Society, the State Medical Society, the American Medical Association, the American Institute of Homeopathy, and the State Homeopathic Medical Society.

—△—

Announcement of Examinations

The next written examination and review of case histories (Part I) for all candidates for the American Board of Obstetrics and Gynecology will be held in various cities of the United States and Canada on Friday, February 7, 1947.

Arrangements will be made so far as is possible for candidates to take the Part I examination (written paper and submission of case records) at places convenient for them. Candidates who successfully complete the Part I examination proceed automatically to the Part II examination to be held June 1–7, 1947 at Pittsburgh, Pennsylvania. Notice of the exact time and place of the Part I and Part II examinations will be sent to all candidates well in advance of the examination date.

Further information and application blanks may be obtained by writing to Paul Titus, M. D., Secretary, 1015 Highland Building, Pittsburgh, Pennsylvania.

Three Doctors Speak in Green Bay

Three Wisconsin doctors lectured on anesthetics and medicine at a conference of the Wisconsin Association of Nurse Anesthetists in Green Bay November 9.

Dr. Wilson S. Phillips, Milwaukee, spoke on "Cyclopropane Anesthesia" at the afternoon session in the nurses' lounge of Bellin Memorial Hospital. At the evening session, after a dinner at the Hotel Northland, *Dr. John J. Boersma*, Green Bay, talked on "Caudal Anesthesia in Obstetrics," and *Dr. Merritt L. Jones*, Wausau, lectured on "Progress in Medicine."

Oxygen therapy was discussed in the afternoon and a film on pentothal sodium anesthesia shown. Another film, "Curare in Pediatric Surgery," was shown in the evening. *Dr. Wendell A. Killins*, Green Bay, presided.

—△—

Brodhead Physician Retires

Dr. E. J. Mitchell, who has practiced medicine in Brodhead since 1904, retired November 1. He has been succeeded by Dr. Frank Swan, a graduate of Loyola University School of Medicine in Chicago.

Doctor Mitchell graduated from Northwestern University Medical School, Chicago, in 1903 and in 1906 was appointed railroad surgeon of the Milwaukee railroad. He served in that capacity until his retirement. He served as Brodhead's city health officer for twenty-five years and as a director on the school board nine years. He is a veteran of World War I and his two sons served in World War II. One son is a dentist in the regular Army and the other, Dr. Robert Mitchell, a 1939 graduate of Northwestern University Medical School is practicing obstetrics and gynecology in Philadelphia.

Doctor Mitchell and his wife left Brodhead November 1 for Florida to remain there until after the holidays before going on to Arizona and California.

—△—

Resident Physician in Rhode Island

Dr. Edward Zamil, Milwaukee, has moved to Newport, Rhode Island, and is resident physician now at Newport Hospital. The doctor was discharged from the Army April 24, 1946 after three and a half years of active service, including two years overseas. His primary duty was that of flight surgeon.

—△—

Dr. G. C. Owen Locates in Milwaukee

Dr. George C. Owen, who was previously reported as practicing in Washington, D. C., has opened offices in Milwaukee for the private practice of internal medicine. After separation from the service April 16, he spent a few months in Washington engaged largely in a joint Army, Navy, and Veterans Administration research project.

FACTS ABOUT THE PREPARATION OF

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Q. How early may these soups be started?

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Society Proceedings

Brown—Kewaunee—Door

M. J. FOX

Dr. Max J. Fox, medical director of Southview Hospital, Milwaukee, and associate clinical professor of medicine at Marquette University School of Medicine, was the guest speaker at the dinner meeting of the Brown–Kewaunee–Door County Medical Society, November 14, at the Beaumont Hotel in Green Bay. Doctor Fox's subject was "Poliomyelitis."

Calumet

Meeting in the City Hall at Chilton, October 24, the Calumet County Medical Society members heard an address by Attorney Jerome Fox of Chilton titled, "Hospital for the County of Calumet." At the election of officers that took place during the meeting, *Dr. N. John Knauf* of Stockbridge was re-elected president, and *Dr. John W. Goggins*, Chilton, was chosen secretary-treasurer.

Dodge

J. T. F. GALLAGHER

The Dodge County Medical Society held its monthly meeting October 31 at the Lutheran Deaconess Hospital in Beaver Dam. *Drs. John T. F. Gallagher, William L. Waskow*, and *Roger E. Henning* of the Jackson Clinic, Madison, discussed "Traumatic Injuries of the Hand," and "Diagnosis and Medical Management of Diaphragmatic Hernias."

The annual business meeting with election of officers was held by the Dodge County Medical Society November 21 at the Lutheran Deaconess Hospital in Beaver Dam.

The following officers, all of Beaver Dam, were elected to serve for the coming year: *Drs. T. C. Clarke, president; W. H. Costello*, vice-president; *A. B. Kores*, secretary-treasurer; *M. M. Temkin*, delegate; *A. B. Kores*, alternate delegate; and *R. R. Roberts, A. M. Rosenheimer*, and *George H. Hoyer*, censors.

Eau Claire—Dunn—Pepin

Members of the Eau Claire–Dunn–Pepin County Medical Society met for their regular monthly meeting October 28 at the Hotel Eau Claire. Dr. O. E. Nadeau of Chicago addressed the group on the subject, "Recurrences following Hernia Operations; their Prevention and Treatment," and Dr. Carl Hedberg, Chicago, the second speaker of the evening, presented a paper entitled, "Management of Diabetes in Surgery."

Fond du Lac

The Fond du Lac County Medical Society members gathered at the Hotel Retlaw in Fond du Lac October 24 for the annual business meeting of the group. Election of officers was held and the following men, all of Fond du Lac, chosen to direct the county society's activities: *Drs. John S. Wier*, president; *Ernest V. Smith, Jr.*, vice-president; and *Jewel S. Huebner*, secretary-treasurer, *Dr. David J. Twohig, Sr.* was elected delegate to the state convention to serve a term of two years, and *Dr. David N. Walters*, alternate delegate.

Grant

At the Municipal Building in Platteville, October 31, the Grant County Medical Society held its annual October meeting with an afternoon program of speeches presented by three Dubuque, Iowa, physicians. Dr. Horace M. Korns gave a talk on "Observations on the Use of Mercurial Diuretics;" Dr. T. J. Greteman spoke on "Backache;" and Dr. R. L. Barton told the group about "Recent Advances in the Treatment of Scabies, Impetigo, and Urticaria." Members and guests adjourned to the Tracy Hotel for dinner following the medical program.

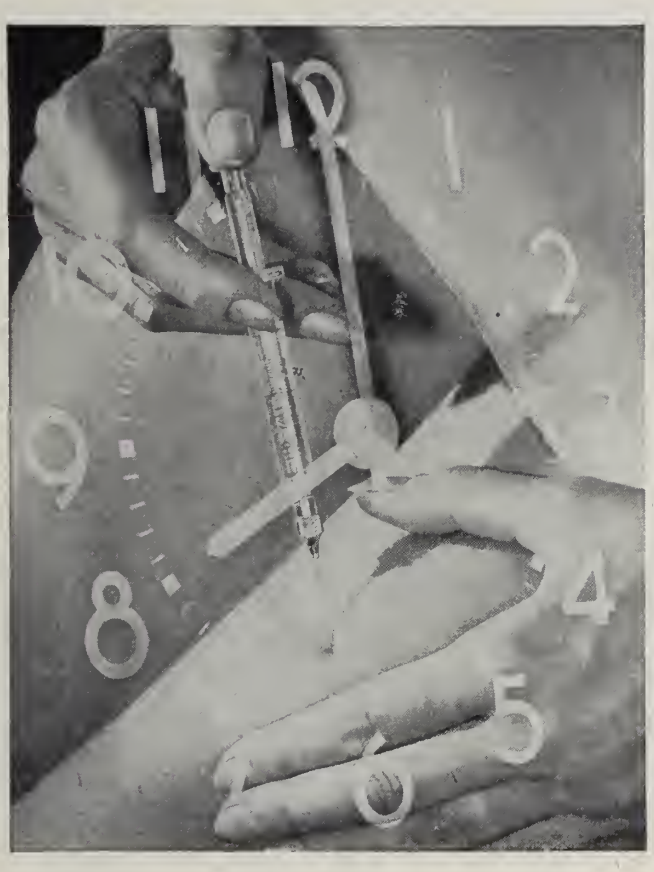
Jefferson

Meeting at the Shorecrest in Fort Atkinson, November 21, members of the Jefferson County Medical Society heard *Dr. J. W. Rastetter*, assistant professor of medicine of Marquette University School of Medicine read a paper entitled, "Jaundice."

La Crosse

Discussion of business matters, election of officers, and a report of the House of Delegates took place at the Stoddard Hotel in La Crosse November 12, when the La Crosse County Medical Society held its

One-injection control of diabetes



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3. ADJUSTMENT OF DIET: Simultaneously adjust carbohydrate distribution of diet to balance insulin activity; initially 2/10, 4/10 and 4/10. Any midafternoon hypoglycemia may usually be offset by giving 10 to 20 grams of carbohydrate between 3 and 4 p.m. Base final carbohydrate adjustment on fractional urinalyses.

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monthly meeting. The business session was preceded by a dinner.

Manitowoc

Members of the Manitowoc County Medical Society gathered at the Manitowoc Hotel November 21, for their regular monthly meeting. Mr. Ralph Weber, executive assistant of the State Medical Society, explained the prepayment care plans sponsored by the State Medical Society, the Wisconsin Plan and the Wisconsin Physicians Service. Activities of the recently created Veterans Medical Service Agency were discussed by Mr. Thomas J. Doran of Madison, director of the Agency.

Milwaukee

Treatment of injuries suffered in household accidents was discussed by *Dr. Paul F. Hausmann*, Milwaukee, at a meeting of the Medical Society of Milwaukee County at the Milwaukee Athletic Club, November 8. Dr. D. R. Nichols of the Mayo Clinic, Rochester, Minnesota, described the recent developments in streptomycin, penicillin, and similar drugs.

Outagamie and Winnebago

The staff of Winnebago State Hospital was host to the Outagamie and Winnebago County Medical Societies at a dinner meeting November 14 at the hospital. *Dr. C. A. Dawson*, president of the State Medical Society, addressed the group and then members of the hospital staff presented a short scientific program. The speeches were as follows: "Foreign Bodies in Gastro-Intestinal Tract" presented by *Drs. F. G. Connell* and *S. R. Beatty;* "Clinical Presentation—Laurence–Moon–Biedl Syndrome," given by *Dr. J. T. Petersik;* and "Depressions—Differential Diagnosis and Treatment," given by *Dr. B. J. Hughes*, superintendent of the Winnebago State Hospital.

Polk

E. T. RECHLITZ

At Yellow Lake Lodge near Webster, Wisconsin, on October 17, members of the Polk County Medical Society were the guests of *Dr. D. A. Maas* of Webster. *Dr. E. E. Carpenter* of Superior spoke at the dinner meeting on the subject, "Planigraph on the Diagnosis of Gallbladder, Kidney Stone, T. B. of the Lung, and Mediastinal Tumor." *Dr. H. A. Sincock* of Superior discussed the paper. A report on the State Medical Society annual meeting, given by *Dr. L. O. Simenstad*, Osceola, was followed by the election of officers. The new officers of the county society are as follows: *Drs. E. T. Rechlitz*, Amery, president; *I. L. Waterman*, Amery, vice-president; *G. B. Noyes*, Centuria; *L. A. Campbell Jr.*, Clayton, censors (for three years;) *L. O. Simenstad*, Osceola, delegate (for two years;) and *V. C. Kremser*, Amery, alternate delegate (for two years.)

The November 21 meeting of the Polk County Medical Society was held in Amery, where the members were the guests of Dr. V. C. Kremser. The evening was devoted to discussions of different subjects pertaining to the betterment of the society, especially to a more systematic outline of a program for the coming year.

Sheboygan

H. W. WIRKA

The Sheboygan County Medical Society, meeting October 31 at St. Nicholas Hospital, Sheboygan; heard talks by two physicians on the subject of poliomyelitis. *Dr. Gustav J. Hildebrand* of Sheboygan entitled his speech, "Public Aspects of the Recent Polio Outbreak in Sheboygan County," and *Dr. Herman W. Wirka* of Madison spoke on "Care of the Convalescent Polio Patient." *Dr. Carl J. Weber* reported on the transactions of the House of Delegates at the State Medical Society's annual meeting in Milwaukee.

Trempealeau—Jackson—Buffalo

Dr. F. G. Anderson of Eau Claire was the speaker of the evening at the Trempealeau–Jackson–Buffalo County Medical Society's meeting November 21 in the MacCornack Clinic, Whitehall. His subject was, "Surgical Aspects of Gastric Ulcer." *Dr. R. L. MacCornack* presented a brief report of the meeting of the House of Delegates of the State Medical Society.

Washington—Ozaukee

The West Bend High School Debate Team presented a debate on socialized medicine November 21 at a meeting of the Washington–Ozaukee County Medical Society in West Bend. Election of officers was also held at the meeting and the following men chosen to direct the activities of the county society; *Drs. R. G. Edwards*, Kewaskum, president; *C. P. Kauth*, Port Washington, vice-president; *P. B. Blanchard*, Cedarburg, secretary-treasurer; *A. H. Barr*, Port Washington, delegate; and *J. G. Hoffmann*, Hartford, alternate delegate.

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"I see Dr. Henry is still in his office."

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SUMMIT NEW JERSEY

Milwaukee Oto-Ophthalmic Society

"Eye and Ear Injuries Under Workmens' Compensation Acts" was the subject chosen by Mr. Harry A. Nelson, director of Workmens' Compensation, State of Wisconsin Industrial Commission, for his speech at the Milwaukee Oto-Ophthalmic Society's meeting November 26 in the Milwaukee Athletic Club, Milwaukee. The scientific program followed a dinner.

Ninth Councilor District

A. R. CURRERI

The fall meeting of the Ninth Councilor District Medical Society was held in Marshfield November 14. At the afternoon clinic, conducted at St. Joseph Hospital, cases presented by the staff of the hospital were discussed by *Drs. A. B. Schwartz* of Milwaukee and *A. R. Curreri*, Madison.

Following dinner served at St. Joseph Hospital Nurses' Home Auditorium, Doctor Curreri spoke on recent advances in thoracic surgery, and Doctor Schwartz discussed new developments in pediatrics.

Wisconsin Surgical Society

Meeting in Milwaukee November 15, the Wisconsin Surgical Society held its inaugural meeting. *Dr. F. Gregory Connell* of Oshkosh gave the President's Address at the dinner meeting and Dr. Frederick A. Coller, professor of surgery at the University of Michigan Medical School in Ann Arbor, was the speaker of the evening. Doctor Coller chose as the subject for his talk, "Abdominal Incisions and Early Ambulation."

Operative clinics were conducted during the morning of November 15 at the Milwaukee Columbia, Veterans Association, and Milwaukee County Hospitals. In the afternoon dry clinics were held in the amphitheater of the Milwaukee Children's Hospital with the following subjects presented and discussed: "Echinococcus Cyst of the Lung and Mucus Secretory Carcinoma of the Lung," *Dr. Forrester Raine;* "Treatment of Extrophy of the Bladder," *Dr. A. A. Schaefer;* "Problems in Shock and Hemorrhage," *Dr. C. Sherrill Rife;* "Treatment of Chronic Radiodermatitis," *Dr. C. R. Dix;* "Perforated Appendicitis in Children," *Dr. Irwin Schulz;* and "Vagotomy in the Treatment of Recurrent Peptic Ulcer," *Dr. Joseph M. King.*

AND ABOUT THE THIRD DISTRICT:

"With a marked concentration of physicians in the Third Councilor District, the *Journal* is assembling all news items pertaining to activities of physicians in Dane, Rock, Green, Columbia, Sauk, Marquette and Adams Counties and presents them together. The *Journal* urges county secretaries to send personal items of interest. Such notices should reach our office by or before the fifteenth of each month before publication."

—EDITOR'S NOTE

SOCIETY PROCEEDINGS

Dane

Dr. Garrett A. Cooper, Madison, named president-elect last year, became the new president of the Dane County Medical Society at the annual business meeting of the group, October 15 at the Madison Club, Madison.

Dr. George G. Stebbins, Madison, was named president-elect and will assume the office of president in October 1947. Other officers of the society elected are as follows: *Drs. N. Alfred Hill*, vice-president; *John K. Curtis*, secretary-treasurer; *J. S. Supernaw* and *L. V. Sprague*, delegates to the State Medical Society; and *B. I. Brindley* and *Harold E. Marsh*, alternates. They are all of Madison. Members elected to the board of trustees are: *Drs. Harry A. Keenan*, Stoughton, and *M. T. Morrison*, Mt. Horeb.

Rock

At the monthly dinner meeting of the Rock County Medical Society, held in the Monterey Hotel, Janesville, October 22, *Dr. Russell F. Wilson*, Beloit was elected president of the society. Doctor Wilson had been acting president since the death of *Dr. E. C. Hartman.* The following men were named to other offices: *Drs. T. W. Nuzum*, Janesville, president-elect; *W. J. Mauermann*, Beloit, secretary-treasurer; *Wayne A. Munn*, Janesville, second dele-

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gate to the State Medical Society, and *Richard A. Thayer*, Beloit, alternate delegate.

Dr. Hertha Tarrasch, Chicago, psychiatrist and director of Rock County Child Guidance Center outlined the program concerning the Center that she hopes to start with the cooperation of the community. Mr. Ralph W. Weber, executive assistant of the State Medical Society presented the two insurance plans being sponsored by the state organization and *Dr. H. E. Kasten*, Beloit, gave the report of the House of Delegates of the State Medical Society.

University of Wisconsin Medical Society

The University of Wisconsin Medical Society met November 5 in the auditorium of the Service Memorial Institutes, Madison, to hear a program presented by members of the University's department of neuropsychiatry.

Dr. William J. Bleckwenn spoke on "What World War II Has Done for Psychiatry," *Dr. Mabel G. Masten* discussed "The Use of Triodione in Convulsive Disorders," and "Dental Caries and Poliomyelitis" was the subject of *Dr. Hans H. Reese's* address.

COUNCILOR DISTRICT NEWS

Doctor Clausen Takes Over Oregon Practice

Dr. Norman Clausen of Madison recently purchased the practice of *Dr. E. S. Johnson* in Oregon, Wisconsin. Doctor Clausen has been serving as head of the New Drug Section, Medical Division, Food and Drug Administration in Washington, D. C. since his release from the Navy in June. Doctor Johnson sold his practice so that he could study more about eye, ear, nose, and throat medicine and specialize in that field.

Doctor Stovall Discusses New Medical Problems

W. D. STOVALL

"Now that we have partially conquered acute disease, the changing emphasis in disease control is toward our chronic ailments," *Dr. W. D. Stovall*, director of the State Laboratory of Hygiene, Madison, told members of the Appleton Woman's Club when he spoke at their meeting October 10 in Appleton. He related how some of the problems of medical science have been solved and described new difficulties, such as the old age problem, that have arisen and must be conquered.

Englishman Addresses Medical Group

Sir Lionel E. H. Whitby, regius professor of physic in the department of medicine, University of Cambridge, London, England, and honorary consulting haematologist to the Royal Army Air Corps, gave the fifth annual A. C. Helmholz lecture of the University of Wisconsin Medical School, November 19 in the auditorium of Service Memorial Institutes, Madison.

Sir Lionel, a friend of *Dr. William S. Middleton*, dean of the medical school, discussed "Haematological Effects of Radiation."

Doctor Miller Starts Private Practice

Dr. James E. Miller, Madison, who returned from military service in September 1945, and since then has completed his three-year residency in orthopedics at Wisconsin General Hospital, has recently opened an office in Madison. His practice is limited to orthopedic surgery and fractures.

Doctor Miller entered the Army in 1941 and served in this country and in Australia, New Guinea, and the Philippine Islands.

University Preceptor's Meeting

The University of Wisconsin Medical School resumed its annual scientific meeting for the associate teaching staff of preceptors on November 22 and 23, in Madison, was presented in the auditorium of the sicians in various localities throughout the state, and carries out a part of the extra-mural teaching of senior medical students. Each fourth year medical student spends twelve weeks with one of the preceptorial groups. This is made possible by making the fourth year of the medical course twelve months in length rather than nine months.

The program, arranged by the medical faculty in Madison, was presented in the auditorium of the Service Memorial Institutes Building and on the wards of the State of Wisconsin General Hospital. The program was as follows:

Friday, November 22

A. M.

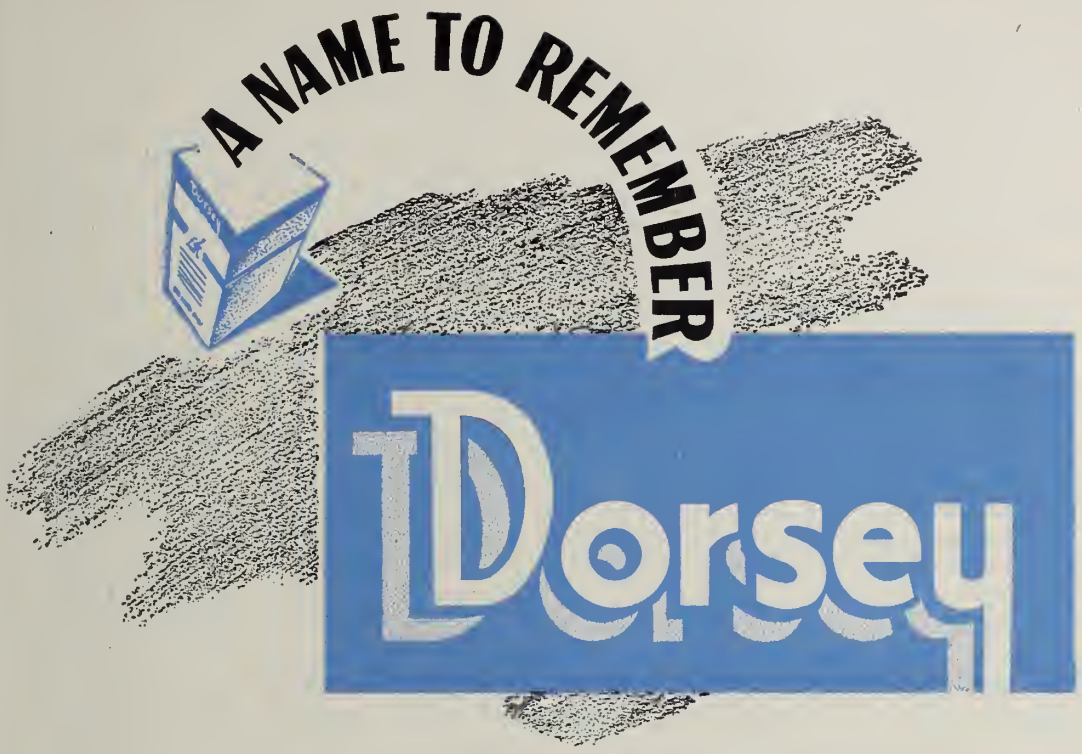
10:00 Symposium on the Anti-biotics, by *P. F. Clark, Ph. D.*, professor of bacteriology, *Dr. O. S. Orth*, associate professor of pharmacology, and *Dr. O. O. Meyer*, professor of medicine.

11:00 "Cutaneous Manifestations of Some Common Medical Conditions," by Dr. Sture A. M. Johnson, professor of dermatology and syphilology.

11:30 "The Management of Some Difficult Metabolic Problems," by *Dr. E. S. Gordon*, associate professor of medicine.

P. M.

2:00 "Fatal Pulmonary Embolism," by *Dr. D. Murray Angevine*, professor of pathology.



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2:30 "Hemolytic Reactions, Transfusions and Erythroblastosis," by *Dr. W. D. Stovall*, professor of hygiene and director, State Laboratory of Hygiene.

3:00 "Electronics in Research and Clinical Medicine," by Dr. W. E. Gilson, research associate in medical electronics.

3:20 "Current Medical and Surgical Aspects of Tuberculosis and Other Thoracic Diseases," by *Dr. Helen A. Dickie*, associate professor of clinical medicine and *Dr. J. W. Gale*, professor of surgery.

4:00 "Some Medical Aspects of World War II," by *Dr. Wm. S. Middleton*, dean, and professor of medicine.

Saturday morning, November 23

A. M.

8:00 to 12:00 Ward rounds and conferences in connection with the several medical and surgical services, State of Wisconsin General Hospital.

A dinner was given by the medical faculty for the preceptors at the Nakoma Country Club the evening of November 22. The group attended the Wisconsin–Minnesota football game November 23.

SOCIETY RECORDS

New Members

James Nissenbaum, 115½ East College Avenue, Appleton.

William C. Felton, 114 West College Avenue, Appleton.

Arthur W. Hoessel, Box 73, Dale.

Francis J. Flanagan, 524 East North Street, Appleton.

Arnold P. Feider, Milford Memorial Hospital, Milford, Delaware.

Harvey K. Guth, Devine Clinic, Fond du Lac.

Stephen H. Ambrose, Whitewater.

Rolf F. Poser, Columbus.

Sigwert W. Simonson, McCornack Clinic, Whitehall.

John W. O'Neill, Menomonie.

Evans Z. Hornberger, Columbia Hospital, Milwaukee.

Frederic A. Thompson, Columbia Hospital, Milwaukee.

Robert H. Cassidy, Columbia Hospital, Milwaukee.

William D. Brand, 2877 North Fifty-First Street, Milwaukee.

William C. Strutz, 2475 North Fiftieth Street, Milwaukee.

Charles M. Schroeder, 208 East Wisconsin Avenue, Milwaukee.

Donald W. Maas, 1222 South Sixteenth Street, Milwaukee.

Edmund J. Schmidt, 2613 West North Avenue, Milwaukee.

Tibor J. Greenwalt, 536 West Wisconsin Avenue, Milwaukee.

John N. Briggs, 5000 West Chambers Avenue, Milwaukee.

Francis F. Rosenbaum, 425 East Wisconsin Avenue, Milwaukee.

James W. Sargent, U. S. N. Hospital, Great Lakes, Illinois.

Charles E. Rogers, 6028 North Kent Avenue, Milwaukee.

Lieutenant Thomas G. Malloy, M. C., Letterman General Hospital, Presidio, San Francisco, California.

Alvin O. Hendrickson, 319 Third Street, Wausau.

William O. Hendrickson, 319 Third Street, Wausau.

Robert L. Hawley, Army Casual Post Office, Fort Lawton, Washington.

Eugene S. Brusky, 101½ North Washington Street, Green Bay.

Harold W. Bruskewitz, 16 South Henry Street, Madison.

Simpson S. Burke, 1300 University Avenue, Madison.

Charles W. Crumpton, 1300 University Avenue, Madison.

Harold J. Tausend, 1300 University Avenue, Madison.

Frank W. Van Kirk, Jr., 1300 University Avenue, Madison.

Henry A. Sjujewski, 1300 University Avenue, Madison.

Richard J. Hennen, 2037 Winnebago Street, Madison.

Emil Gutman, 319 Third Street, Wausau.

Eugene E. Skroch, 2037 Winnebago Street, Madison.

Changes in Address

L. A. Gay, Madison, to Research Hospital, Kansas City 8, Missouri.

Leonard Gorenstein, La Crosse, to 3910 North Forty-Fourth Street, Milwaukee.

C. S. Williamson, Green Bay, to 913 Grand View Drive, Albuquerque, New Mexico.

J. H. Wishart, Eau Claire, to 3048 Fourteenth Avenue, South, Minneapolis, Minnesota.

R. C. Hartman, Janesville, to 208 North Twelfth Street, McAllen, Texas.

C. R. Newman, Milwaukee, to 19 Frederick Street, Rhinelander.

Stella M. H. Sikkema, Madison, to 3011 Broadway, Boulder, Colorado.

J. T. McCoy, Madison, to State Sanatorium, Statesan.

William Van Zanten, Oostburg, to 902 North Eighth Street, Sheboygan.

L. F. Sherman, Siren, to Department of Surgery, Veterans Hospital, Minneapolis, Minnesota.

P. W. Limberg, Milwaukee, to Glenwood City.

N. M. Clausen, Washington, D. C., to Oregon.

The Season's Greetings

To lay a log of wood upon the fire
To dress the fir tree in its gift attire
To wish you happiness and cheer
To bring you peace throughout the year.

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A. L. Van Duser, Wisconsin Rapids, to 1505 Pear Street, Ann Arbor, Michigan.

H. A. Weisse, New Holstein, to Plymouth Clinic, Plymouth.

Landers Finseth, Marshalltown, Delaware, to 525 East Michigan Street, Milwaukee.

R. C. Darby, Mishicot, to Wautoma.

Gorton Ritchie, Madison, to Columbia Hospital, Milwaukee.

E. E. Bertolaet, Palmyra, to Wisconsin State Board of Health, Madison.

C. S. Yaillen, Milwaukee, to 14536 Hamlin Street, Van Nuys, California.

B. R. Walske, Arcadia, to Veterans Administration, Marion, Indiana.

N. B. Wagner, Racine, to 250 Eleventh Avenue, N. E., St. Petersburg 4, Florida.

W. D. Brand, Milwaukee, to 2015 Twentieth Street, South, St. Petersburg, Florida.

W. E. Bayley, La Crosse, to 2400 South Street, Lafayette, Indiana.

DEATHS

Dr. Bernard J. Bertram, Algoma physician for the past eight years, died at his home, Wednesday, October 30 at the age of 34. Death followed an illness of approximately one month.

Born in Barton, May 22, 1912, the doctor attended high school in West Bend and later entered Marquette University School of Medicine, Milwaukee, graduating in 1937. After a year of internship at St. Mary's Hospital, Milwaukee, he established his practice in Algoma.

Doctor Bertram was a member of the Brown–Kewaunee–Door County Medical Society, the State Medical Society, and the American Medical Association. During his years in Algoma, Doctor Bertram was active in community affairs, serving as president of the Algoma Junior Chamber of Commerce when it was organized in 1941 and later as a director of the Chamber of Commerce. He took an active interest in the proposed new Algoma Memorial Hospital.

Surviving the doctor are his wife and three sons.

Dr. Lewis Frick, 76, of Athens, who retired several years ago after practicing medicine in Athens for almost thirty years, died Thursday, October 31 at a Marshfield hospital.

Doctor Frick was born January 9, 1870 at Elkhart Lake. A member of the 1897 graduating class of the University of Illinois College of Medicine in Chicago, he practiced in southern Wisconsin for several years before locating in Athens in 1915.

The doctor was a member of the Marathon County Medical Society and the State Medical Society, and was a Fellow of the American Medical Association.

Interested in civic affairs, he was a member of the Athens Advancement and Agricultural Association. He was known by members of the fur industry for breeding large numbers of silver fox and mink on his farm in the town of Bern.

Doctor Frick is survived by his wife, two daughters, and a son.

Dr. Helen J. Kelly of Milwaukee died suddenly at her home Tuesday, October 29. She was 40 years old.

Doctor Kelly was born in Calumet, Michigan, moved to Milwaukee, and then graduated from Marquette University, receiving a Bachelor's Degree in philosophy and science, in 1925. She taught bacteriology at the State Board of Health in Louisville, Kentucky, for a while before entering the University of Minnesota Medical School in Minneapolis. After graduation in 1939 she practiced medicine in Louisville where her husband, John W. Kelly, was director of public health service. Doctor Kelly did postgraduate work in Boston, Chicago, and New York. When her husband died a year and a half ago Doctor Kelly returned to Milwaukee and continued her medical practice.

Surviving the doctor are her mother, five sisters, and two brothers.

Dr. Frederick H. Kuegle, 68, who was associated with the Munn–Koch Clinic and Mercy Hospital in Janesville until his health failed three years ago, died at his Janesville home, Tuesday, November 12.

The doctor, who was born in Ohio, graduated from the University of Nebraska in 1899 and from Creighton University School of Medicine in Omaha in 1905. Doctor Kuegle did postgraduate work in Vienna, Austria, in 1914, and at one time was associated with Beloit Hospital as radiologist. A specialist in roentgenology and radiology, he located in Janesville in 1926. He was a veteran of World War I.

Doctor Kuegle was a member of the Rock County Medical Society, the State Medical Society, the American Medical Association, and the Radiological Society of North America, Incorporated. He was also a Diplomate of the American Board of Radiology.

The doctor is survived by his wife.

Dr. Herman F. Ohswaldt, 89, Oconto Falls, said to have been Wisconsin's oldest practicing physician until he gave up his work several months ago, died Tuesday, October 22 in an Oconto Falls hospital after a short illness. The doctor had completed sixty-five years of service as a physician and surgeon in the state.

Doctor Ohswaldt was born April 17, 1857 in New York City. He worked as a barber in New Jersey until admitted to Bellevue Hospital Medical College, New York. He graduated in March of 1879. The doctor began his practice in Waverly, New York, but moved to Green Bay in February 1881. Doctor Ohswaldt was associated with the elder Dr. W. H. Bartran there for four months before moving to Stiles. He located in Oconto Falls in 1920. With the exception of six years spent as doctor with the Sagola (Michigan) Lumber Company and the Milwaukee Railroad, he resided in Oconto County ever since.

He was a member of the Oconto County Medical Society, the State Medical Society, and the American

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Medical Association. The doctor served as city health officer of Oconto Falls for many years and also was city physician. Several years ago business men and patients annually set aside a day when he was honored at a banquet, "Ohswaldt Day."

Surviving Doctor Ohswaldt are his wife and two daughters.

Dr. William S. Stanley, 69, who practiced medicine in Milwaukee for over forty years, died Sunday, October 27 in his home in Milwaukee. Doctor Stanley had been in ill health and semi-retirement for the last several years.

The doctor was graduated from Milwaukee Medical College in 1900 and then opened his office in Milwaukee.

A member of the Medical Society of Milwaukee County, Doctor Stanley also held membership in the State Medical Society and the American Medical Association.

The doctor's wife and two daughters survive him.

Dr. William G. Doern, 68, physician and surgeon in Milwaukee for forty years and president of the staff of Mercy Hospital, Milwaukee, since 1936, died Sunday, November 3 in Milwaukee. He had been in ill health for some time.

Doctor Doern was a 1902 graduate of Keokuk Medical College, College of Physicians and Surgeons in Iowa, and in 1907 was awarded the first M. S. degree issued by Marquette University.

Surviving the doctor are his wife, two daughters, and a son.

Dr. Maud F. Pratt of Springbrook, who retired from the practice of medicine in 1932 because of ill health, died at a Madison hospital Monday, October 28. She was 74 years old.

Born in Eagle Point township September 15, 1872, Doctor Pratt moved to Hayward as a child, and later to Springbrook. After teaching school at Jim Falls and Springbrook, operating a general store, and serving as postmistress of Springbrook, she decided to study medicine in 1905. She was graduated from Milwaukee Medical College in 1909.

Following several years of teaching school in Everett, Washington, Doctor Pratt was admitted to medical practice in 1911, and was a physician in Springbrook until 1913. She opened a maternity hospital at Appleton, operating it until 1920 when she moved to Shell Lake. She practiced there for two years, and successively served on the medical staffs of the Northern Hospital at Oshkosh, Mendota State Hospital, Mendota, the Independence Hospital for insane patients at Independence, Iowa, and the Logansport State Hospital for mental patients at Logansport, Indiana, until she retired.

The doctor was a former member of the Outagamie County Medical Society, the State Medical Society, and the American Medical Association. At one time she served as treasurer of the Wisconsin Women's Medical Association.

Doctor Pratt is survived by two daughters, a son, and two foster children.

BIRTHS

A son to Dr. and Mrs. Frederick G. Gaenslen, Milwaukee, on August 13.

A son to Dr. and Mrs. Elmer J. Shabart, Chicago, on October 17.

A son to Dr. and Mrs. L. V. Littig, Madison, on October 28.

A son to Dr. and Mrs. Luther E. Holmgren, Madison, on November 7.

A daughter to Dr. and Mrs. Edward Zamil of Newport, Rhode Island, formerly of Milwaukee, on November 19.

INTENSIVE COURSE IN CARDIOLOGY

Presented by the University of Wisconsin Medical School

The Medical School of the University of Wisconsin has announced a series of brief, intensive courses for physicians in this state. They will be of five days duration and are to be given at the Medical School and the State of Wisconsin General Hospital in Madison. The first of these offerings will run from Monday through Friday, January 13 to 17, 1947 inclusive, and will cover the field of Cardiology. The work will include electro-cardiographic interpretation, orthodiascopy, hypertension and hypertensive heart disease, the treatment of the arrhythmias, rheumatic fever, sub-acute bacterial endocarditis, and other aspects of heart disease. This course is intended for the general practitioner and will be under the supervision of Drs. C. M. Kurtz and H. H. Shapiro, and the teaching staff will include other members of the medical faculty. The work will be fundamentally of a practical character intended to present the current diagnostic and therapeutic measures available. The fee will be $25 for the five day course.

Further details may be obtained from Dr. Llewellyn R. Cole, Coordinator of Graduate Medical Education, The Medical School, 418 North Randall Avenue, Madison 6, Wisconsin.

WISCONSIN PHARMACISTS

The pharmacies listed on this page have been recommended as rendering the type of prescription service in keeping with high medical standards.

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★ CHIPPEWA COUNTY ★

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(ORGANIZED 1929)

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Mrs. A. J. McCarey, Green Bay, Immediate Past-president
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Mrs. G. D. Reay, Onalaska, Corresponding Secretary
Mrs. N. A. Hill, Madison, Treasurer

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Mrs. E. H. Rettig, Milwaukee

Circulation of Bulletin—
Mrs. H. J. Hansen, Sheboygan Falls

Organization—
Mrs. E. J. Carey, Wauwatosa

Postwar Planning—
Mrs. G. B. Ridout, La Crosse

Convention—
Mrs. D. B. Dana, Kewaunee

Address of 1946-1947 President*

By MRS. JAMES C. FOX
La Crosse

Mrs. James C. Fox
La Crosse
1946–1947 President

TODAY the Auxiliary to the State Medical Society of Wisconsin begins a new year. A year filled with the hopes of peace and the problems of a postwar world. To me, a comparative neophyte in the Auxiliary you have given the responsibility of being your president. It is with a deep feeling of solemnity that I accept this honor, and may I assure you that despite my apparent inadequacies, I shall expend every effort to be worthy of your trust and confidence. May God give me the physical strength, the moral courage, and the mental sagacity to serve you faithfully and well.

As we enter this, the nineteenth year of our organization, it is well to pay tribute to our leaders, both local and national, who have been an inspiration to us and who have so ably guided the Auxiliary. To the Advisory Committee of the State Medical Society we are deeply indebted for their counsel and guidance. We pledge our loyalty to our national organization through whom our efforts are united and directed. We are an integral part of 28,000 women whose duty it is to interpret the doctor's ideals and philosophy to the public. Although we must never forget to promote friendly relations among doctors' families in our own community, still we no longer exist as just a social group, but render a real service to the American Medical Association and to the people.

Our purpose, to serve as an Auxiliary to the medical profession, is accomplished through the activities of the officers and all the committees. Upon each of the members rests the responsibility of further extending these activities.

We desire to include all eligible women in our membership. In joining the Medical Auxiliary one does not add one more thing to an already crowded life, but receives guidance in a privilege that we as doctors' wives already have. County auxiliaries which were disbanded during the war should be reorganized, and we will try to organize auxiliaries in the remaining counties of the state. Where it is impractical to organize as a county Auxiliary we will encourage members-at-large. The members-at-large will not have the advantages of an organized Auxiliary, but will be placed on the mailing lists of our committees and will be informed of the activities of our organization. It is vitally important that we, as doctors' wives, be well informed so we may play a prominent part in the discussion and actions of health problems in our social contacts as well as in other organizations.

The handbook for state Auxiliaries is available at the central office* at a cost of 25 cents. All officers

* Presented before the Eighteenth Annual Meeting of the Woman's Auxiliary to the State Medical Society of Wisconsin, Milwaukee, October, 1946.

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and county presidents need this excellent manual for reference in regard to administration responsibilities and committee duties. Keep informed by making it a habit to read *The Wisconsin Medical Journal* and the *Journal of the American Medical Association.*

It is my wish that each county president and the state and county chairmen of all committees subscribe to the Bulletin, our national Auxiliary publication. The Bulletin gives official and timely information helpful in formulating plans and activities and is needed as a guide in expressing policies for our organization.

Hygeia is the only magazine with authentic information on health published in this country, and through its editorials the people are given a true analysis of the problems of medical economics. The *Hygeia Hand-Book* gives the workers all information pertinent to *Hygeia.* The national *Hygeia* chairman has requested your cooperation in a survey of schools, institutions, public reading rooms, and reception rooms of all professionals in the community to ascertain where *Hygeia* is in use and to what extent. We accept this task, for in so doing we can be of real service.

The archives chairman will continue to collect and file all material of state Auxiliary importance. This includes the histories of our doctors and records of the doctors in service.

Our philanthropic work on various projects such as loan closets, sewing for hospitals, gifts, and other charities has always been a credit to our organization and as such will continue.

As a result of the war many social changes have taken place and the consequent adjustments will follow. During the war, our government necessarily exercised broad control on our lives. Various necessities of life such as food, certain types of clothing, and heat were proportionally distributed; certain industries and transportation facilities were operated by the government. A greater proportion of people were on the government payroll than ever before, and many were endorsing plans of their employer, the government. But if we the people are the government in a democracy, who is sponsoring these plans for the federal control of medicine? We are aware of the communistic influence in our country that would try to substitute a national socialistic state in place of our present democratic government. It would be well if the people could see as clearly that the government control of medicine is also a socialistic movement against free enterprise. The Wagner–Murray–Dingell Bill and the Pepper Bill are dead, but the forces behind these bills are very much alive. Our effort must be expended to combat these influences. Our legislative chairman will keep us informed on the bills before congress which are of interest to us, and whether or not they are approved by the American Medical Association.

The ten point program or the National Health Program is the American Medical Association's solution of our present problem in medical economics. It is the program whereby the public can protect itself against the economic catastrophe of serious illness. Study it carefully. It is enlightening to have programs on the organization of the American Medical Association and the accomplishments of its various councils, committees, and bureaus. Health education in all its phases is the basic program material. There is excellent material for health education in the fields of cancer and tuberculosis control, animal experimentation, juvenile delinquency, child welfare, and recreational planning. New electrically transcribed radio health programs are available. Advertise these programs.

At the annual meeting of the Woman's Auxiliary to the American Medical Association held in San Francisco July 1–4, 1946, the War Service Committee was changed to Postwar Planning. This committee will direct the study of prepayment medical care plans of the state and county medical societies in the United States, and particularly the prepayment plans of Wisconsin.

The Committee on Public Relations interprets the medical profession to the people. The public should understand that the doctors have devoted their lives to the service of mankind, and continue to do so when they oppose the government control of medicine. The issue of compulsory insurance is to be the subject of national debate in all secondary schools during the coming school year. When we aid those debating our point of view, we help the youth of today. We aim to reach the individual citizen who must think and act on the issues of the day. As Ralph Barton Perry has so succinctly put it, "It is evident that . . . the strength of righteousness is proportional to the strength of its friends and inversely proportional to the strength of its enemies."

All committees will work to meet the specific request of the House of Delegates of the American Medical Association to inform ourselves on the hazards of current medical legislation, and then bring this information to the public. To accomplish this end we will put forth all effort to comply with the three specific recommendations made to constituent Auxiliaries by the national organization at the San Francisco convention. Briefly they are: (1) to hold an annual school of instruction for the training of officers and chairmen in their duties; (2) to form study groups within the organization for a better understanding of the Auxiliary program, especially in regard to medical legislation; and (3) to institute a midyear conference in each state Auxiliary, following the plan of the national conference.

This year we again have the pleasure and privilege of meeting at convention. May the delegates return home charged with the solemn obligation to carry out the purpose of the Auxiliary, and filled with the inspiration for doing it.

---

* Woman's Auxiliary to the American Medical Association, 43 East Ohio Street, Chicago 11, Illinois.

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High Lights of Talk Given Before the Eighteenth Annual Meeting

By MRS. JESSE D. HAMER
National President

THE Woman's Auxiliary to the American Medical Association was organized in 1922, and will celebrate its twenty-fifth anniversary at the end of this Auxiliary year, namely in June 1947.

Forty-two states and the District of Columbia have organized Auxiliaries with a total membership of over 28,000.

During the twenty-five years of the Auxiliary's existence many worthwhile achievements have been accomplished. At the recent meeting of the Board of Trustees of the American Medical Association, held in San Francisco, two very important actions were taken on behalf of the Auxiliary. Henceforth the entire Board of Trustees will serve as the Advisory Council to the Auxiliary and will meet with the Board of Directors of the Auxiliary twice a year, at the mid-year Board meeting and immediately preceding the Annual Meeting. The second action taken provides for housing the Auxiliary's Central Office at A. M. A. Headquarters. As soon as space can be allocated, the office will be moved to the American Medical Association Building. The Auxiliary has proved that it can be a valuable asset to the medical profession, and the two actions taken by the Board of Trustees should be a challenge to all Auxiliary members. They should stimulate the members to greater interest and effort. In the future there will no doubt be a much closer relationship between the two groups, which should be beneficial to the medical profession, the Auxiliary, and the general public.

The advancement of health and health education is one of the primary objectives of the organization. To this end, the constituent Auxiliaries carry on active programs of their own, and also cooperate with other organizations in their respective communities which are interested in the public welfare Auxiliary members can and do render valuable service to their communities by assisting in formulating sound health programs and by correctly interpreting the aims and purposes of the medical profession in vital health issues to other groups. Many Auxiliaries sponsor health institutes which are open to the public. Speakers' bureaus are maintained and radio talks on important health questions are arranged and supervised. *Hygeia* magazine, which is published by the American Medical Association and furnishes authentic health information, is one of our most effective means of promoting health education to the lay public. By placing *Hygeia* in places where it is accessible to the lay people, the Auxiliary is rendering a valuable community service. Members of the Auxiliary throughout the country are urged to take an active part in the promotion of health education through other health agencies, such as the American Cancer Society, the Anti-Tuberculosis Association, and the National Foundation for Infantile Paralysis.

The work of the Medical and Surgical Relief Committee of America, which consists of collecting and sending medical and surgical supplies to the war-torn countries in Europe, has the approval of the Woman's Auxiliary to the American Medical Association. Several state Auxiliaries have already sent hundreds of pounds of such material to the committee, which has reconditioned the articles and has sent them to the needy countries.

The Auxiliary's second objective, that of cultivating friendly relations and promoting mutual understanding among physician's families, is of utmost importance. If we have friendliness and friendship among the members, we can have unity. There never has been a time when there was a greater need for unity than there is today. The Auxiliary is urged to extend the atmosphere of friendliness to other groups, so that the organization will be looked upon by these groups as one that is understanding and cooperative in community interests.

The national Auxiliary stresses the importance of being informed about pending health legislation and voluntary health insurance providing for the prepayment of medical care plans. The entire membership of the Auxiliary is urged to become thoroughly familiar with the National Health Program of the American Medical Association, which is an adequate answer to those who allege there is no alternative to a federally controlled system of compulsory health insurance.

The members of the Auxiliary share not only the honor but also the responsibilities of the medical profession. The Auxiliary can and must serve as a training school for its members. There is no other means of obtaining the information regarding the vital issues confronting the medical profession. Our membership must be increased if the Auxiliary is going to meet the responsibility which it now faces.

As we carry on our Auxiliary work day by day, let us be mindful of the fact that if we are loyal and faithful in our service to all the people, we are also making it possible for the medical profession to continue to live up to its ideals of unselfish service.

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THE JOURNAL BOOKSHELF

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, S. M. I. Building, Madison, Wis.

Gastro-Enterology. By Henry L. Bockus, M. D., Professor of Gastro-enterology, University of Pennsylvania Graduate School of Medicine. Volume III: The Liver, Biliary Tract and Pancreas, and Secondary Gastro-intestinal Disorders. Pages 1091 with 427 illustrations. (In three volumes, totaling 2700 pages with 900 illustrations, and separate desk index, $35.00) Philadelphia and London: W. B. Saunders, Company, 1946.

The continued development of the field of internal medicine is exemplified by the appearance from time to time of special works covering systems within the broader fields, this time by the completion of the third and largest volume of a series on gastro-enterology by Bockus and an associated group of eminent clinicians. This volume follows the same general plan of the first two volumes published previously and covers the liver, biliary tract, pancrease, parasites, and secondary intestinal disorders. Many treatises have been published heretofore on various phases of gastro-enterology, but never before has there been brought together as extensive a survey of the entire system.

The chapters on the liver and biliary tract alone take up 700 pages or two-thirds of the entire volume. By diagram, chart, illustration, and photograph a most comprehensive understanding is obtainable of the anatomy, physiology, anomolies, and diseases of the hepato-biliary system. Laboratory methods for the study of liver function are presented in detail.

Although given minor emphasis, the important role of psychosomatic medicine has not been neglected and has been discussed under the title "Functional Disorders of the Gastro-intestinal Tract of Neuropsychiatric Origin." Then, too, there are important chapters on gastro-intestinal allergy, the inter-relationship of gastro-intestinal and cardiac disorders, pulmonary tuberculosis, and genito-urinary disease. The final chapter is devoted to the much neglected subject of food poisoning and includes a differentiation of poisoning from bacterial toxins, chemicals, plants, animals, and the infections borne by food.

It is to be expected that in a work of such wide scope for some omissions to occur, and for differences of opinion as to emphasis. Except for a statement as to differential diagnosis of tumors of the ampulla of Vater, nothing is presented on the benign papillomata, carcinomata, and the various sarcomata of the ampulla.

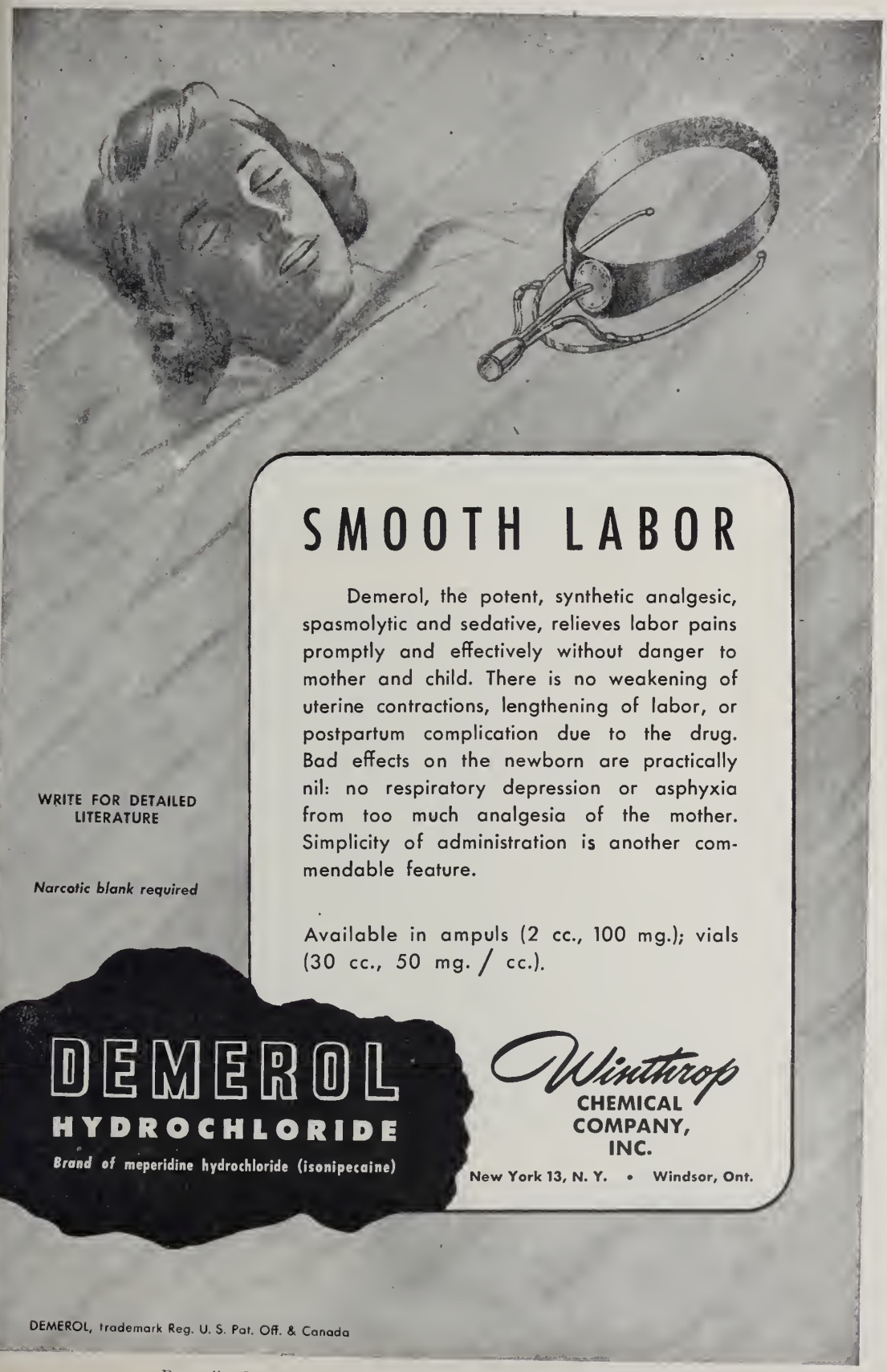
As a reference and a text for both clinician and student, this system is to be most highly recommended. It is unique in the absence of confliction of opinion probably because of the close association of the contributors, all of whom are members of the faculty of the University of Pennsylvania Graduate School of Medicine. K. L. P.

The Progress of Medical Geography. By Richard Upjohn Light. A Proposed Atlas of Diseases. By J. K. Wright. Pages 654 with charts. New York: American Geographical Society (Reprinted from The Geographical Review) 1946.

World War II has served to focus for the physician the peculiar and frequently incomprehensible relationship between disease and geography in the broadest sense. The nature of the world today is such that we can no longer be indifferent to the exotic diseases on the grounds that they exist at great distances and therefore present no danger to our population. However, beyond the mere fact of the danger of disease, is the fundamental problem of why certain diseases show peculiar geographic distributions. Any knowledge that can be gained as to the determining factors in such relationships would obviously contribute significantly to our understanding of the diseases themselves and therefore their control. Thus any program designed to inform the epidemiologist and physician as to the geographic considerations of disease should be enthusiastically encouraged. Such a program has been under consideration by the American Geographical Society and recently has led to the holding of a conference of outstanding medical men and members of the Council of the Geographical Society. As part of the program a brief historical background was presented by Dr. Richard V. Light which is appended to the main report of the conference under the title "The Progress of Medical Geography." The conference voted to undertake a project for an Atlas of Diseases and expressed a preference for consideration of the following ten diseases: cholera, the typhus group, malaria, yellow fever, goiter, plague, beriberi and pellagra, filariasis, encephalitis, and schistosomiasis. This reprint deals essentially with the minutes of the conference and contains an appendix of cartographic considerations and terminology of map symbols. P. P. C.

The American Hospital. By E. H. L. Corwin, Ph. D., Executive Secretary, Committee on Public Health Relations. The New York Academy of Medicine; Honorary Charter Fellow of The American College of Hospital Administrators; Former Secretary General and Honorary President of The International Hospital Association. Pp. 226. The Commonwealth Fund, 1946. Price $1.50.

The author has accomplished a difficult task in presenting a vast amount of information in a book of only 226 pages. This is accomplished to a con-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The discussions of the historical development, financing, construction, distribution, utilization, control, internal organization and operation, and external influences of American hospitals are written in a concise and interesting manner. They reflect hospital trends which enable the author to anticipate future problems, and to recommend policies to meet these problems.

The brevity of the book limits its usefulness as a textbook for the student of hospital administration, but enhances its value as a reference book for the experienced hospital administrator and medical historian. L. L. W.

Clinical Roentgenology of the Heart. By John B. Schwedel, M. D., Associate Attending Physician, Medical Division, Adjunct Attending Physician, Department of Roentgenology, Monteifore Hospital, New York; Attending Electrocardiographer and Associate Visiting Physician in Medicine, Gouverneur Hospital, New York; Lieutenant Commander, M. C. (V. S.), U. S. N. R. Pp. 380 with 749 illustrations. New York: Paul B. Hoeber, Inc. Medical Book Department of Harper and Brothers, 1946. Price $12.00.

This profusely and very well illustrated volume covers in a most comprehensive manner the subject of cardiovascular roentgenology. The principles of teleoroentgenography and orthodiagraphy are both clearly presented. The roentgenologic aspects of all types of cardiovascular disease are discussed and there is an excellent chapter on congenital defects. Each clinical condition is illustrated by one or more appropriate roentgenograms each of which is accompanied by a clarifying line-drawing or diagram and a concise clear-cut explanation. An occasional electrocardiogram is included whenever it is helpful in supplementing or confirming the x-ray findings. The text, which is more or less obscured by the abundant illustrations, is brief, direct and easily readable. To each chapter is appended an excellent and very complete bibliography.

There is not a great deal of adverse criticism to be directed at this book. Possibly the importance of "inflow tracts" and "outflow tracts" has been somewhat overemphasized, and, in the opinion of the reviewer, the term "pulmonary conus" is employed much too loosely and in many instances incorrectly. Angiocardiography has demonstrated that the true pulmonary conus normally is buried in the body of the heart and does not contribute to the left border of the cardiovascular shadow. This same procedure also has confirmed the original contention of Eyster that the segment of the upper left cardiac border lying between the "point of opposite pulsations" and the pulmonic arch (pulmonary artery) is formed by a portion of the left atrium and properly can be designated the "left auricular salient." The latter has in itself a distinct and specific clinical significance of real practical importance which has been overlooked by the author.

In spite of these relatively minor differences of conception and opinion the reviewer feels that on the whole the book is beautifully done, the material is exceptionally well presented, the illustrations are excellent and the field of cardiovascular roentgenology is comprehensively covered. Doctor Schwedel's work contributes materially to the understanding of a most important phase of cardiology and roentgenology. The book should be of immense practical value to the internist, the cardiologist, and roentgenologist and can be highly recommended. C. M. K.

Anesthesia in General Practice. By Stuart C. Cullen, M. D., Head of Division of Anesthesiology, Department of Surgery, State University of Iowa Hospitals; Associate Professor Surgery (Anesthesiology), State University of Iowa College of Medicine. Pp. 260, illustrations and charts. Chicago: The Year Book Publishers, Inc., 1946. Price $3.50.

This book is a text and reference source for the non-specialist who occasionally must administer an anesthetic. The subject matter is concise, but covers all the fundamental aspects of an administration from preanesthetic medication to postanesthetic care. Inhalation, spinal, regional, infiltration and topical anesthesia are discussed with illustrations of the technics. In addition, there are short but complete chapters on the airway, signs of anesthesia, choice of agent and technic, oxygen therapy, shock, and the hazards of fire and explosion. An innovation is the very effective use of cartoon-like illustrations. The author writes with authority for which he is well qualified. The book should be valuable also for medical school teaching, the interne, and the beginner in the specialty. M. H. H.

Principles of Dynamic Psychiatry. By Jules H. Masserman, M. D., Division of Psychiatry, Department of Medicine, University of Chicago. Pp. 322 with 4 plates. Philadelphia and London: W. B. Saunders Company, 1946. Price $4.00.

The author has done considerable animal experimental work for the purpose of insight into the basic principles of neurotic reactions. In this book he attempts to integrate this type of approach with dynamic psychology. The first part of the book deals with the scope of psychiatry, the latter defined by

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the author as a science of human behavior. A critical discussion of the various theories of behavior follows. The second part, "attempts to reformulate and integrate these theories into a biodynamic organon of behavior." A "biogynamic theory" of normal and abnormal behavior is the result the approach must be holistic and not prejudiced by "physiologic," "psychologic," nor even "psychosomatic" part—concepts. In a succeeding volume which is in preparation, the author will proceed with the application of the biodynamic principles to the technics of behavioral diagnosis and to the various methods of therapy.

This book the reviewer feels is mainly for the physician specializing in psychiatry since the reading requires intimate knowledge of the psychiatric literature. For the psychiatrist it will be stimulating. F. K.

Electrocardiography in Practice. By Ashton Graybiel, M. D., Captain, Medical Corps, U. S. Naval Reserve, Co-ordinator of Research, U. S. Naval School of Aviation Medicine, Pensacola, Florida, and Paul D. White, M. D., Lecturer in Medicine, Harvard Medical School; Physician, Massachusetts General Hospital; with the assistance of Louise Wheeler, A. M., Executive Secretary, The Cardiac Laboratory, Massachusetts General Hospital and Conger Williams, M. D., Assistant in Medicine, Harvard Medical School and Massachusetts General Hospital. Second Edition. Pp. 458, 323 illustrations. Philadelphia and London: W. B. Saunders Company, 1946. Price $7.00.

This second edition remains a practical volume on electrocardiographic interpretation. The principles and technic of electrocardiography are well handled. The scope of the precordial leads has been broadened. The use and practical application of the unipolar and esophageal leads is presented. Illustrations of normal variations are more numerous, enriched by the service experience of one of the authors. Rhythm variations, compiles in an excellent table on arrhythmias, are interestingly and simply analyzed, as are the electrocardiographic patterns of diseases of the heart of intrinsic nature and extrinsic influence. The useful section of "test" electrocardiograms with a new series of cases is again included. The clear illustrations, very liberal use of the precordial leads, the method of approach and the close tie-up between the clinical picture and electrocardiographic interpretations, recommend this book to all those interested in electrocardiography. H. H. S.

Fluorine in United States Water Supplies. By Anastasia Van Burkalow. Pages 177–193 with map. New York: American Geographical Society (Reprinted from The Geographical Review) 1946.

As a pilot project of a program by the American Geographical Society, designed to prepare an Atlas of Diseases, a survey of the fluorine content of United States water supplies was undertaken. A number of studies on the relationship between the dental health of individuals and the fluorine content of their water supply has been carried out on a regional basis. More recently the United States Public Health Service has become actively engaged in this program and has been able to confirm the earlier reports of a striking relationship between dental health and fluorine content of communal water supply. In the present project, four survey maps of the United States dealing with the fluorine content of communal and other water supplies are presented. The methods of collecting data and their classification are presented in detail. The presence and absence of fluorine in the different waters is discussed from the geologic and geochemical standpoint. Pathologic effects of fluorine are briefly discussed. The need for better data on the fluorine content of potable and agricultural waters is emphasized by the author. This pamphlet should prove of real value not only to those interested in the relationship of fluorine to dental health, but also to all physicians and scientists interested in the influence of the natural environment on health. P. P. C.

Mitchell–Nelson Textbook of Pediatrics. Edited by Waldo E. Nelson, M. D., Professor of Pediatrics, Temple University School of Medicine. With the collaboration of 49 contributors. Ed. 4. Pp. 1350 with 519 illustrations. Philadelphia and London: W. B. Saunders Company, 1945. Price $10.00.

This textbook of Pediatrics, edited by Waldo E. Nelson, is a successor to the old Griffith and Mitchell which has been completely rewritten with the aid of authors who are recognized authorities in their fields. In this book more space has been devoted to the important problems of growth and development, the care of the premature infant, and the problems of the adolescent child. All sections of the text are very well written but the reviewer was particularly impressed by the contributions on disturbance of fluid and electrolyte equilibrium, and the sections on the digestive system, rheumatic infection, and the anemias of infancy and childhood. K. B. McD.

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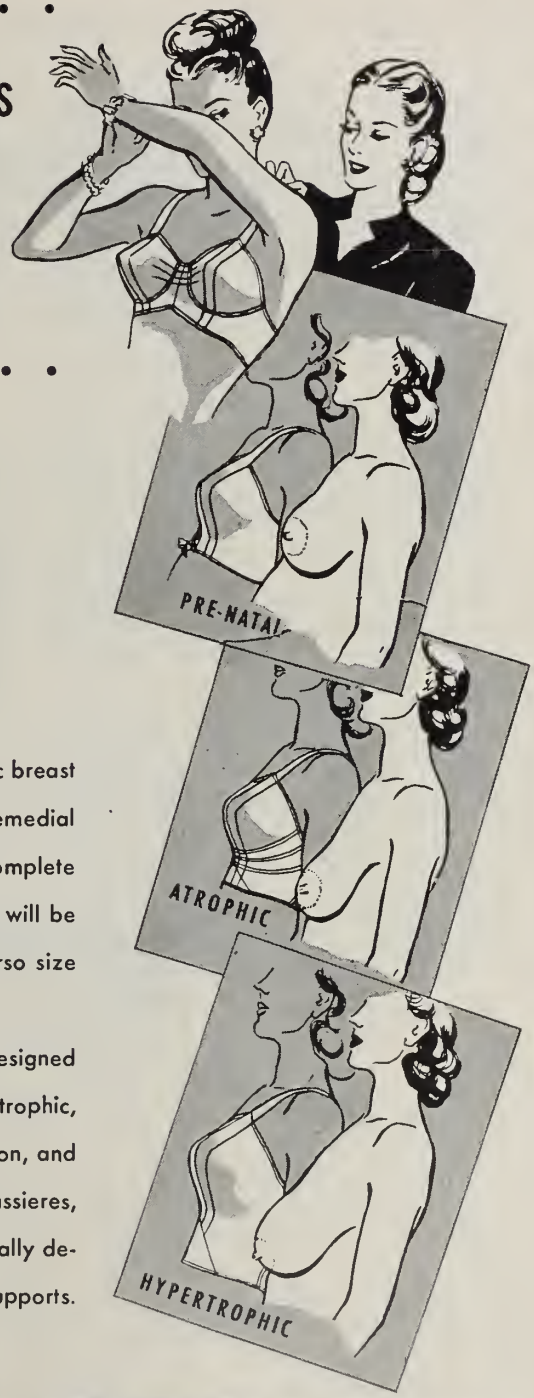

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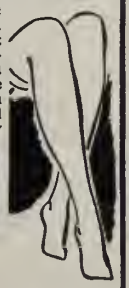

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The
MEDICAL FORUM

The Wisconsin Medical Journal February, 1946

PEPPER BILL CRITICIZED BY MADISON PEDIATRICIAN

Medical Attendants to Be Licensed By State Board Examination Scheduled For February

Madison—An examination for licensure of medical attendants, to be held in Madison February 26, results from the new law (Section 149.065 of the Wisconsin Statutes) passed by the 1943 Legislature through the joint efforts of the Wisconsin Conference of Catholic Hospitals, the Wisconsin State Nurses Association, the Wisconsin Hospital Association, and the State Medical Society.

An indication of competency is given by licensure of those who care for the sick, according to Miss Leila I. Given, Secretary of the State Board of Nurse Examiners. A new step in state health service, it protects both the patient and the attendant nurse.

At the time the bill was introduced in the Legislature, its sponsors felt that the creation of the "licensed attendant," a new category of nursing assistant, would help to relieve the acute shortage of registered nurses. This type of worker is already recognized in twelve other states.

Eligibility Requirements

To be eligible for the examination applicants must be: (1) a United States citizen (or have legally declared intention of becoming one), (2) at least 19 years of age, (3) of good moral character, (4) a high school graduate or its equivalent, and (5) a graduate of an approved school for attendants connected with a hospital having a minimum daily average patient-census of 40, or an equivalent training. Payment of a $5 fee is required.

Any person licensed as an attendant in another state whose standards are at least equivalent to those of Wisconsin may be licensed without examination; the fee for licensing by reciprocity is $10.

THE SENATOR SAYS—

The Editor
Wisconsin Medical Journal
917 Tenney Building
Madison 3, Wisconsin

Dear Sir: In your November issue, you quote Dr. William K. Trimble's criticism of my plea for comprehensive medical care prepayment plans. Dr. Trimble bases his case on the grounds that we have "in the United States the lowest infant mortality of any Nation on this earth, the lowest maternal mortality in the world, the lowest incidence of communicable disease, the safest water and food supply in the world, the greatest number of corrected defects of any Nation on the globe," etc. I wish it were so. Unfortunately it is not.

According to the careful studies of the U. S. Bureau of the Census (based on the reports of fifty-three nations), the following countries reported lower infant mortality rates than did the United States in 1938, the year before the invasion of Poland by Hitler: Sweden, Switzerland, Netherlands, Norway, Australia, New Zealand and Iceland. Countries reporting lower maternal mortality than the United States in 1938 included Sweden, Switzerland, the Netherlands and Norway. In 1944, England and Wales reported a lower maternal mortality than the United States. International comparisons of life expectancy and crude death rates indicate that we are even farther from the top of the list of these health indexes. As far as I have been able to determine from health experts, no reliable international comparisons exist for the incidence of communicable disease, safety of water

(Continued on page 8, column 2)

DOCTOR TENNEY CALLS FOR LOCAL ADMINISTRATION OF CHILD HEALTH PROGRAMS

Detroit—Declaring that Senator Claude Pepper's bill S 1318 calls for the "complete abrogation of state and local participation in the formulation of policies," Dr. H. Kent Tenney of Madison, speaking before the legislative session of the

H. Kent Tenney

American Academy of Pediatrics meeting in Detroit January 15–18, emphasized that "child health programs would suffer rather than benefit from its enactment."

"There are certain aspects of medical practice where individual physicians, local agencies, state agencies, and federal agencies can and should pool their efforts. And we believe that such pooling of efforts can result in definite benefit to all concerned," said Doctor Tenney, "but it is our unalterable contention that the policies and practices that govern the activities of these agencies should be determined locally. We feel that, in spite of fairly frequent visits to the state by representatives of federal bureaus, we still know our conditions and our problems better than anyone remote from the scene can ever know them. And it is this

(Continued on page 2, column 1)

TENNEY—

(Continued from page 1, column 3)

complete and utter abrogation of state and local rights which it calls for that makes bill S 1318, or any reasonable facsimile thereof, so very unpalatable to us in Wisconsin. When one considers the endless over-lapping and duplication of existing programs that this bill provides for it is no wonder that many of our administrators view it with alarm."

Will Lead to Confusion

"Our opposition to the bill does not stem from a fear of losing our practice but rather from a conviction that the bill will lead to so much confusion and resentment as to seriously hamper maternal and child health activities," Doctor Tenney stated, emphasizing that present plans require considerable amplification.

"It has been said that this bill puts the health of children in the same category as their education," continued Doctor Tenney. "But, our system of public education and the provisions of bill S 1318 are so diametrically opposed as to make any such comparison entirely untenable. Every school district elects their own school board which decides its own policies with a minimum of participation by even the state officials. But bill S 1318 would completely reverse this system and require the Chief of the Children's Bureau to formulate all rules and regulations for the medical, dental, 'and related services' of every political unit of every state."

Give Funds to State Boards

Doctor Tenney suggested that "if the Congress would allot to the State Board of Health, or other responsible agency, its share of the proposed appropriation, and require that body to be guided by a committee representing medical, dental, hospital, and lay groups, then it would be possible to develop plans, tailored to fit local conditions, and free from the administrative strings that are always attached to Federal funds." However, he argued that "in the case of bill S 1318 the strings have grown to be more like rubber bands that will snap your money out of your hands if you don't watch out."

Doctor Tenney outlined Wisconsin's expanded program as including: (1) doubling the number of public health units in the state, (2) creating within the State Board of Health a full-time Director of Education whose duty it would be to organize and conduct a continuous program of postgraduate medical courses, as well as lay education, throughout the state, (3) increasing the number of Public Health Nurses in many areas of the state, and (4) placing an increased emphasis on pediatric training, with a great expansion in the whole field of preventive medicine in view.

In commenting on the above program, Doctor Tenney said, "It is little short of suicidal for organized medicine to sit on its haunches and howl about proposed plans without proposing some positive plans of its own."

Bradley Appoints Hawley in Medical Branch of VA and Outlines Policies

Salaries Named and Training Privileges Made Attractive

Washington—General Paul R. Hawley has been named to serve as Acting Chief Medical Director of the newly created Department of Medicine and Surgery in the Veterans Administration, announces General Bradley. Professional personnel will be brought by this act (Public Law 293) into an organization comparable with the Army and Navy Medical Corps and the United States Public Health Service.

The employment of physicians, nurses, and dentists was authorized by General Bradley to fill existing vacancies, and there is an immediate need for 1,125 doctors, 1,200 nurses, and 100 dentists.

Among the major provisions are:

1. Specialists certified by VA will be paid 25 per cent more salary up to a ceiling limit of $11,000 a year.

2. Residencies will be set up in VA hospitals where younger doctors may study to qualify as specialists. This will mean that veterans will be able to obtain the most up-to-date medical treatment—the same kind as if they were admitted to hospitals connected with the nation's leading medical schools and centers.

3. Promotions will be made on recommendations of special VA boards which, in general, compare with the "selection boards" operating in the Army and Navy for higher ranking officers.

4. Office of Chief Medical Director. The director will be paid a salary of $12,000 a year. A Deputy Medical Director will receive $11,500 and Assistant Medical Directors—not to exceed eight in number—will be paid $11,000 each.

5. Medical Service.

Chief grade, $8,750 minimum to $9,800 maximum.

Senior grade, $7,175 minimum to $8,225 maximum.

Intermediate grade, $6,230 minimum to $7,070 maximum.

Full grade, $5,180 minimum to $6,020 maximum.

Associate grade, $4,300 minimum to $5,180 maximum.

Junior grade, $3,640 minimum to $4,300 maximum.

6. Appointments of key executives will be for a four-year term, subject to removal by the Administrator for cause. Reappointment will be for the same term.

7. Doctors, dentists, nurses, and technicians now employed by the VA will be continued on their present jobs pending determination of their qualifications for appointment in the new medical department.

8. Another provision of the act which will permit professional improvement of VA medical personnel will allow up to five per cent of such employees to study or do research work for periods of time up to 90 days. This will enable doctors, dentists, nurses, and technicians to attend recognized schools or work with the United States Public Health Service or other research groups. Officials pointed out that this would enable workers to keep abreast with the very latest developments in their respective fields.

9. Although they are not subject to selection or promotion by Civil Service, the members of the new VA Department of Medicine and Surgery will be under the Civil Service Retirement Act of 1920 and will receive its benefits.

General Hawley commenting on the President's action said:

> "With the signature of the medical department act, our objective is clear—a medical service for the veteran that is second to none in the world."

It is said that some of the social planners are invoking the old saw to the effect that often the only thing the opposition has in common is opposition.

This may not be true of opposition to the Wagner-Murray-Dingell-Truman proposals, but proponents of the measure are bent on finding out. It is rumored that various sections of the bill will be heard on widely separated occasions, so that opposition will appear scattered and without uniformity of interest.

One of the potent objections to the proposed law is that it would vest control in the federal government. If this were to come about, it would seem plausible to remove the states from control of unemployment benefits and the like.

* * *

Observation in this column in September, 1945: "It is said that many large hospitals in Michigan intend to withdraw unless the Blue Cross management increases the per diem rate."

Item in various newspapers dated about January 10 of this year: 14 Detroit hospitals have withdrawn their cooperation with the Michigan "Blue Cross" insurance plan. Other hospitals in the Detroit area may take the same step, according to the chairman of a committee of the greater Detroit Hospital Conference.

* * *

New York state apparently is contemplating a stiff fight on anti-vivisection legislation. The profession and other interested groups have organized the Friends of Medical Research, with an executive secretariat.

* * *

It is rumored that the New York State Commission on medical care, appointed by Governor Dewey in the fall of 1944, contemplates a report that is far from acceptable to the medical profession which now charges that the commission contains an inadequate number of physicians who are representative of the general practice of medicine. The Governor is urged to reconstitute the Commission by the appointment of "additional active practitioners of medicine."

* * *

The State Legislature of Virginia also created an interim committee to study health problems in that state. Unlike the rumors pertaining to New York, it is said that the committee does not feel that it is advisable to recommend any compulsory program at this time.

Instead, it is suggesting further appropriations to support a broad publicity program including hospital insurance. One main concern will be with the problem of school children's health.

* * *

And highlights in Wisconsin: the state vocational board is studying a state-wide fee schedule for government-financed physical restoration work . . . the motor vehicle department will have some medical problems in the new financial responsibility law for drivers—if a driver is not insured and is involved in an accident causing property and personal injury, he must post bond for those damages—consequently there must be an evaluation of physical injury . . . the State Board of Health is considering possibilities of operating a blood bank . . . the 1946 Assembly of the Inter-state Postgraduate Medical Association will be held in Cleveland October 15 to 18 . . . A survey will shortly be conducted of hospitals in this state with reference to war surplus commodities they might be able to use . . . Did you know that the Blue Book issue was distributed to all junior and senior medical school students.

SUPREME COURT ORDERS JUDGE TO REVOKE HILLSBORO MD LICENSE

Madison — Reversing an appeal from the Circuit Court of Vernon County, the State Supreme Court ordered the revocation of the medical license of Dr. Otterbein D. Willstead, Hillsboro. Doctor Willstead was convicted in the United States District Court, on January 27, 1944, of selling narcotics.

State Board Asks Revocation

Dr. C. A. Dawson, secretary of the State Board of Medical Examiners, at that time asked the Vernon County district attorney to institute proceedings to revoke the doctor's license on the basis that a "conviction involving moral turpitude" had transpired, sufficient grounds for such action according to the Wisconsin Statutes.

Turned over to the attorney general's office by the district attorney, the case appeared before Judge Cowie, who refused to grant the judgment. The state appealed to the Supreme Court, which on January 8 reversed the judgment and ordered revocation of the license.

That the conviction, and not the facts upon which it was grounded, is cause for revoking the license, according to the statutes, was pointed out in the decision written by Justice John Wickhem of the Supreme Court.

BACK FROM THE WARS, DOCTOR?

If you have just returned from the Armed Services, we are reminding you to reinstate your TIME Accident & Health policy.

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GENERAL LULL JOINS AMA AS ASSOCIATE MGR

Major General George F. Lull, who has accepted the assignment of Associate General Manager of the American Medical Association and has already reported for active work, retired from the Army after thirty-three years of service with the Medical Corps. His notable record as Deputy Surgeon General won him the Distinguished

GEORGE F. LULL

Service Medal, the highest noncombatant award. The citation stated that as Chief of the Personnel Service, General Lull was largely responsible for the development of policies and studies which resulted in outstanding achievements in the Army's medical program.

Active in World War I

Early in World War I he commanded a base hospital at Camp Beauregard, Louisiana, and later organized and commanded Base Hospital No. 35 of the A.E.F. From 1922 until 1926 General Lull was Director of the Department of Preventive Medicine at the Army Medical Center. In 1929 he was appointed Medical Advisor to the Governor General of the Philippine Islands, where he served for three years. He had charge of the Vital Records Division of The Surgeon General's Office from 1932 to 1936.

The following four years he was Director of the Department of Sanitation at the Medical Field Service School, Carlisle Barracks, Pennsylvania. In 1940 he returned to The Surgeon General's Office as Chief of Personnel Service until May 31, 1943, when he was appointed Deputy Surgeon General.

Born in Pennsylvania March 10, 1887, General Lull received his M. D. degree from Jefferson Medical College in 1909, a Certificate of Public Health from Harvard Technology School of Public Health in 1921, and his degree of Doctor of Public Health from the University of Pennsylvania in 1922. He is an honor graduate of the 1913 class of the Army Medical School.

Home For Aged and Convalescent Hospital Urged to Supplement Facilities in Madison

Doctors Vingom and Stovall Secure Initial Approval of County Board

Madison—Construction of a 200- to 400-bed institution near the Madison General Hospital to serve as a home for the aged, convalescent home, and place for chronic invalids, and abolishment of the present home for the aged at Verona, were urged at the January 8 meeting of the Dane County Medical Society by Drs. C. O. Vingom and W. D. Stovall, proponents of the resolution which was adopted without dissent.

Placing homes for the aged, and similar institutions, near medical centers in populous places is the trend throughout the state, as was pointed out by Doctors Vingom and Stovall. Present medical standards seek to preserve constant social contacts with normal life for such individuals, and the proximity of homes for the aged to medical centers would make available better care for these needing attention.

Facilities Urged For Years

A convalescent hospital in Madison to supplement existing medical facilities has been urged for years by local physicians, according to Doctor Vingom, who said: "There is a shortage of hospital beds right now, and those who are chronically ill must pay the full hospital rates, when they could get just as good care in a convalescent hospital at half the cost. We are on the threshold of a big expansion in medical and hospital facilities. Madison in a few years will be a big medical center, and we shouldn't be asleep now to needs of the future."

A survey to study the problem of care of the aged in Dane County, declared to be under consideration by the trustees of the county home and asylum at Verona, followed the County Society resolution. With an appropriation of $5,000 for architectural and engineering work on a new home from the county board, the trustees, together with other interested agencies, have discussed but not yet decided upon the nature and location of the new home.

"Piecemeal Planning" Charged

"Piecemeal planning" and the isolation of the aged in the country were criticized by Edna Nicholson, Chicago, Director of the Central Service for the Chronically Ill, who spoke before the meeting of the trustees to urge the close relating of the new home to hospitals and medical services, thus allowing those with curable ailments to receive adequate diagnosis and treatment. That the care of the aged will be a continuing and increasing problem was emphasized by Miss Nicholson because better medical care is causing more people to live to more advanced ages, when they are prey to chronic disease requiring bed care.

The following comments were made in an editorial appearing in the Capital Times, January 17:

> **"The Dane County Medical Society has offered a suggestion for planning for future care of the county's aged which should command the thoughtful consideration of the city and county authorities. . .**
>
> **We believe that the county should make a study of the medical society's proposal as well as thoroughly exploring every angle to see to it that the best system of care is developed. In the interests of both efficiency and humanitarianism it is time that we began planning our public welfare on something besides the present stop-gap and piecemeal system. . .**
>
> **We hope that county and city authorities will see fit to explore the possibilities of the medical society's recommendation and to call on experts in the field for counsel and assistance."**

"IOWA POLL" SHOWS OPPOSITION TO TRUMAN PLAN

MANY FAVORING COMPULSORY INSURANCE OBJECT TO PROPOSED PAYMENTS

Des Moines, Iowa—More opposition to the compulsory health insurance plan recommended to Congress by President Truman than approval is shown in Iowa by the "Iowa Poll," a survey conducted every two weeks by the Des Moines Sunday Register to obtain Iowan public opinion on current topics.

A picture of Iowa opinion on the president's proposal is given by the responses to the following question:

"President Truman recommends that congress pass a law setting up compulsory health insurance. Under his plan, sickness expenses such as doctor bills, hospital bills, and dentist bills would be paid by the government out of a new tax on people's earnings. Do you think congress should pass such a law?"

	Total	Men	Women
Yes	40%	42%	39%
No	49%	51%	48%
No opinion	11%	7%	13%

Even among those who favored the plan, only about 29 per cent would be willing to pay the necessary 4 per cent of their income, as indicated by the survey, conducted among a representative cross section of the state, according to Henry J. Kroeger, general manager of the Iowa Poll.

Opinions on the adequacy of medical care now available, an influencing factor on public feeling concerning compulsory health insurance, were revealed by the following questions:

"Do you (and your family) have a regular doctor you usually go to when you are sick?"

	Total	City	Town	Farm
Yes	84%	81%	86%	86%
No	16%	19%	14%	14%

"During the past year, did you ever feel you ought to see a doctor and then decide not to go after all?"

	Total	Men	Women
Yes	48%	41%	53%
No	48%	54%	44%
Don't remember	4%	5%	3%

When those 48 per cent who answered "yes" were questioned as to their reasons for staying away when they felt they should have seen a doctor, the following answers were among those received: too busy, doctor too busy, felt better before got around to it, and, finally, for financial reasons.

An analysis of the need for the removing of financial obstacles in the path of good health, advanced as one of the main arguments for compulsory health insurance, is found in the following tabulation of answers to the question, "Did you ever put off going to a doctor because you felt you couldn't afford it?":

	Total	City	Town	Farm
Yes	36%	36%	39%	35%
No	61%	62%	59%	61%
Don't remember	3%	2%	2%	4%

MEDICAL EXAMINERS TEST 89 APPLICANTS

Eighty-nine applicants for licensure to practice medicine and surgery were examined by the State Board of Medical Examiners, meeting in Madison on January 8, 9, and 10. Of this number thirty took the written examination and fifty-nine applied for licensing by reciprocity.

Three applicants for license to practice massage and hydrotherapy were given the written examination; six applications for licensure by reciprocity to practice osteopathy were received.

NEWS FROM THE BOARD OF HEALTH

■ **TENTH HEALTH DISTRICT APPROVED:** A tenth health district comprising Douglas, Washburn, Burnett, Polk, and Barron Counties, to be put into effect as soon as personnel can be obtained, was approved by the State Board of Health in its December meeting. Ten districts were authorized by the Legislature, but only nine were set up originally. Five districts remain without medical officers, however, and these vacancies will be filled before the new district is staffed.

■ **ROCK RIVER BASIN TO GET CLEAN-UP:** The Rock River Basin was designated "number one" in the state-wide stream sanitation clean-up program by L. E. Warrick, state sanitary engineer, who outlined sewage disposal improvements and elimination of stream pollution due to 543 waste-producing industries in the 3,500 square mile area as the goals of the postwar activity of the state sanitary engineers and local health authorities.

■ **ALLAN FILEK NAMED SUPERVISOR OF LOCAL HEALTH SERVICES:** Dr. Allan Filek, Madison, was appointed supervisor of local health services by the State Board of Health at its January meeting. He will also continue his duties as director of the tuberculosis division until a qualified physician can be obtained to fill his former post, but in the meantime the board asked him to undertake close supervision of local health services throughout the state, at a time when five districts are without medical health officers.

ALLAN A. FILEK

■ **HIGHER SALARIES FOR STATE BOARD OF HEALTH DOCTORS:** Higher starting salaries for district medical men and an increased salary scale for all State Board of Health physicians may soon be in effect, following recommendations made by the State Board of Health to the bureau of personnel. Dr. Carl N. Neupert, state health officer, recently appeared before the bureau to urge the need for higher salaries if able medical men are to be attracted to public health posts.

Director of Handicapped Children Division Reports Wide Scope of Medical Activities

Powell Stresses Need For Closer Coordination to Forestall Federal Control

If expanding federal aid programs, with resultant direction of state plans, are to be forestalled, there must be closer cooperation among existing state agencies concerned with the care of crippled children, according to Frank V. Powell, director of the Bureau of Handicapped Children, who, in presenting a six-year progress report to the Advisory Committee on the Care of Crippled Children on December 9, outlined the wide scope of medical activities carried on under the direction of his department. He particularly scored the Pepper Bill (S-1318) and warned that the acceptance of the federal program would go far beyond the preliminary appropriation of $100,000,000.

Patient–Physician Relationship Held

In outlining the varied medical program carried out through his department, Mr. Powell emphasized the care which is taken to retain the relationship between patient and family physician, especially in instances when specialized medical service is required, as in the case of orthopedic clinics. He reported success in resisting an attempt of federal authorities to supplant the referral type of service with one of open clinics whereby patients present themselves for examination without previous medical examination.

Two medical problems which Mr. Powell felt required more study and coordination between various interested groups concerned the spastic child and those suffering from epilepsy.

"There should be some council or committee of educational and medical persons to consider legislation and policies which vitally concern both," said Mr. Powell. "There are few programs for handicapped children which should not be joint programs . . . Today the health agency, the welfare agency, and the education agency all talk about programs for the whole child. If three agencies are to take care of the whole child they can do it through coordinated or separate programs. Separate programs are costly in money, time of personnel, and to the child. We are developing a social conflict between agencies which is comparable to the one between the armed forces. What is happening seems to me to be so obvious that it is time to appeal to the public in the name of good government practice rather than professional interests.

"A complete job for all children has not been done by any agency. Let's admit it and let's endeavor to have a program for a better job directed by those who have some known-how rather than by the crackpots on a narrow phase of a program of need."

SOCIETY COMMITTEE PROBES POSSIBILITY OF ESTABLISHING EYE-BANK

Work Would be Correlated With National Project

Interest in the possibility of having an eye-bank established in Wisconsin, in line with the recently announced project of the National Society for the Prevention of Blindness, has prompted the Committee on Visual Defects of the State Medical Society to review the national program and determine how it can best be correlated with existing Wisconsin resources. Members of the committee who are assisting with the study are Drs. J. K. Trumbo, Wausau, chairman; R. P. Sproule, Milwaukee; and A. H. Pember, Janesville.

National Bank Planned

The project, sponsored through the National Society for the Prevention of Blindness, is intended to establish a national eye-bank in order to make available to hospitals and surgeons who are qualified to perform the corneal graft operation a supply of fresh or preserved corneal tissue. The objectives of the program are to: (1) extend, by teaching and research, the knowledge and skill required to perform the operation; and (2) establish sources of supply of salvaged eyes and corneal tissue.

The present plan is to have facilities established in New York to which any eye might be sent for complete pathologic study and a report sent to the institution which

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Special classrooms for orthopedic cases are maintained in several Wisconsin cities. Picture at the left shows ramp used by students at Washington School, Madison. Massage treatment shown at right.

ACTION TAKEN AGAINST MERRILL PRACTITIONER

River Falls—A quo warranto proceeding was commenced recently by the Attorney General, at the request of the Wisconsin State Board of Medical Examiners, against Mrs. Lydia Donner, 201 North Center Street, Merrill, Wisconsin. The complaint alleges that Mrs. Donner does not possess a Basic Science certificate and does not possess a license to practice medicine and surgery, osteopathy, or osteopathy and surgery, but that notwithstanding her lack of such qualifications, she has engaged in the practice of medicine. The complaint demands judgment against her, directing that she cease and desist from such illegal practices and from holding herself out as a practitioner of medicine and as one authorized to treat the sick.

Establishes Precedent

"The outcome of this case should be of interest to the medical profession," said Mr. Kenneth White, attorney for the State Board of Medical Examiners. "If the Attorney General is successful in this case, it will establish a precedent for use in other cases. The common method of procedure in cases of violations of the Medical Practice Act is by a criminal prosecution. In some cases this is effective but in many cases the illegal practitioner pays a fine and goes on to another community where he again takes advantage of the public. It is thought that quo warranto may be more effective than criminal prosecution in putting such illegal practitioners entirely out of business."

State Prescribes Conditions

Pointing out that the State has prescribed conditions governing the practice of law, medicine and other professions, having in view the general welfare and safety of the community, Mr. White said, "It has made such practice a franchise or privilege which can be exercised only by those who comply with the prescribed requirements. When an individual engages in such practice without having obtained the necessary license, the action which the State brings against him to force him to cease such illegal practice, is known as a quo warranto proceeding. In brief, it is a demand made by the State upon the individual to show by what right he is exercising some franchise or privilege appertaining to the State which he cannot legally exercise, except by virtue of authority from the State. The judgment in such cases is similar to the judgment in injunction actions in that it orders the illegal practitioner to cease and desist from further illegal activities and if the individual fails to obey the judgment of the Court, he is subject to summary proceedings for contempt of court."

MILK PRODUCERS DRAFT STRONG REPORT OPPOSING FEDERALIZED HEALTH PROGRAMS

EYE-BANK—

(Continued from page 6, column 3)

supplies the eye, on request; also, bacteriologic studies will be made for possible contamination. Institutions desirous of making their own pathologic examination will have the eye returned to them in the proper preservative fluid.

Initially, the needed space and personnel has been made available in the Manhattan Eye, Ear, and Throat Hospital, New York. It is hoped that as the demand for service increases branches can be established in various parts of the country.

State Bank A Possibility

"Naturally this is of great interest to all Wisconsin ophthalmologists," said Doctor Trumbo, when commenting on the program. "Our Committee is anxious to assist with this worthy project, and we are taking steps to see if state resources might be used so that a state eye-bank might be established for Wisconsin citizens who would benefit by this particular operation. The corneal graft operation is, of course, only effective in one type of blindness—that caused solely by opacity of the cornea when the rest of the eye and optic nerve are normal. It is estimated that there are between 10,000 and 15,000 blind persons in the United States who might benefit by correct corneal graft, so the need for such a program in Wisconsin, as elsewhere, is apparent."

WISCONSIN MAN HEADS COMMITTEE TO STUDY PROBLEM

Recommending the encouragement of prepaid medical, hospitalization, and dental insurance plans on a voluntary basis, a special committee of the National Cooperative Milk Producers' Federation recently developed a series of recommendations, following its study of Senator Robert F. Wagner's proposal to create an extension of social security benefits into the medical care field.

Madison Man Chairman

The Federation appointed, to study the proposal, a special committee composed of Milo K. Swanton, Chairman, Executive Secretary, Wisconsin Council of Agriculture (Coop.), Madison; Leon A. Chapin, Treasurer, Dairymen's League Co-operative Association, New York City; and Forrest C. Fairchild, Manager, McLean Company Milk Producers' Association, Bloomington, Illinois. Highlights of the report follow:

Wide Range of Coverage

"We recommend that the various matters covered in S–1050, and any similar bills, be segregated when such legislation is to be considered by Congress so that each subject may be appropriately considered on its own merits.

"We recognize that there exists a need for federal aid to improve the health standards of the nation through the expansion of hospital, medical, and dental facilities and services.

"We recommend that the President appoint a committee of 13 persons, the Chairman of which shall be the Surgeon General of the United States, to conduct detailed studies, surveys, and investigations to measure the adequacy of existing hospital, medical, and dental facilities and services, in cooperation with the proper state agencies or committees; and to determine the extent to which such facilities and services are inadequate . . .

"The aforesaid committee shall be composed of, in addition to the Surgeon General, 4 members rep-

(Continued on page 8, column 3)

FOLKE BECKER AGAIN HEADS STATE CANCER DRIVE

Madison, Wis. — Folke Becker, president of the Rhinelander Paper Company, has been named Wisconsin campaign manager for the 1946 cancer fund solicitation, by Eric Johnston, national campaign manager for the American Cancer Society, New York City.

Mr. Becker is serving his second year as Wisconsin state campaign

MR. FOLKE BECKER

manager. Since 1914, when he came to the United States from Sweden, he has been closely associated with the paper industry in the East and in Wisconsin. Besides being head of the Rhinelander Paper Company since 1935 he has been active in many community enterprises as well as serving as director of the Wisconsin Chamber of Commerce and president of Trees of Tomorrow, Incorporated.

When announcing the appointment of the Wisconsin campaign director, Johnston said of Mr. Becker:

"Last year, in our intensified drive for funds through the American Cancer Society, Mr. Becker helped raise more money for cancer research and cancer education than had ever been secured in Wisconsin. With the assistance of the Field Army we feel confident Wisconsin will meet its quota."

Funds will be solicited in April, which has been designated annually by presidential proclamation as "Cancer Month."

SCARCITY OF MDS IN POSTWAR YEARS PREDICTED BY U. S. LABOR AUTHORITIES

SURVEY INDICATES SPECIAL SCARCITY IN PSYCHIATRY, OB, AND ORTHOPEDICS

On the basis of statistics compiled in Washington, as reported in the December, 1945, issue of the *Monthly Labor Review*, it is apparent that statisticians of the U.S. Department of Labor are of the opinion that the scarcity of physicians will continue in the immediate postwar years.

In reviewing the occupational outlook for physicians the statistical study points out that from 1910 to 1940 the net addition of 13.4 per cent of the "medical labor force" was far behind the 43.2 per cent increase in population for the same three decades. It was also noted that the replacement needs have been affected by the age composition of the physicians. The number of physicians 65 years and over rose from 7.9 per cent of the total in 1920 to 10.1 per cent in 1930 and 11.5 per cent in 1940.

Wide Range of Coverage

The wide range of medical coverage was also shown in the fact that in New York in 1940 there were 511 persons per physician, while in Mississippi the ratio rose to 1,635.

Pointing out that the number of physicians will not increase appreciably in the immediate post-war years, since the number gained by the accelerated training program during the war was offset by: (1) deaths of older physicians, (2) retirement or reduced capacity in the older groups, and (3) mortality of younger physicians serving with the armed forces, the Bureau predicts there will not be a sufficient number of doctors to meet the increased needs for their services, especially in certain specialized fields such as psychiatry, obstetrics, and orthopedics.

PEPPER—

(Continued from page 1, column 2)

and food supply, and number of corrected defects.

Even if the Doctor's argument were correct, however, it would still be no logical ground on which to base a case against comprehensive medical care prepayment plans. The facts remain that our health *can* be much better, and the lack of comprehensive medical care insurance makes for financial barriers to high quality care.

Ours is a great and good world but it can be a better world and making it a better world is the duty and privilege of all of us.

I am afraid that Dr. Trimble's argument is just one more expression of a desire to maintain an undesirable *status quo*, by stating that "this is the best of all possible worlds."

Sincerely yours,
CLAUDE PEPPER, *Chairman*
Subcommittee on Health and Education

MILK PRODUCERS—

(Continued from page 7, column 3)

resenting the medical profession, 2 members representing the dental profession, 2 members representing business and other professions, 2 members representing labor, and 2 members representing agriculture.

"We recommend that Congress appropriate $5,000,000 for the purpose of conducting such studies and surveys. After such studies have been completed we recommend that Congress appropriate such sums, based upon need as may be determined by such studies, to be necessary for grants and loans to states and local governments to aid in the construction of such facilities and services.

"We recommend the encouragement of prepaid medical, hospitalization, and dental insurance plans on a voluntary basis.

"We deem the subject of unemployment insurance, including the payment of all benefits and maintenance of all governmental employment services, to be one which can be best handled by the various individual states and therefore recommend that these functions be retained in their present status."

The
MEDICAL FORUM

The Wisconsin Medical Journal March, 1946

PREPARE SURVEY TO DETERMINE STATE NEEDS IN CHILD HEALTH

Constructive Program for Improvement of Medical Care Adopted by AMA

Fourteen-Point Program Extended by Trustees

Chicago, Feb. 16—The Board of Trustees of the American Medical Association and the Council on Medical Service of the American Medical Association at a meeting just completed in Chicago have taken a long step toward protection of the American people against the costs of sickness through participation in a voluntary prepayment sickness plan now developed under the authority of the American Medical Association.

Standards For Medical Care Plans

The fundamental step in the development of this plan was the establishment of standards of acceptance for medical care plans which have the approval of the Council on Medical Service of the American Medical Association. Any plan which meets the standards of the Council will be entitled to display the seal of acceptance of the American Medical Association on its policies and on all of its announcements and promotional material. In order to qualify for acceptance, the prepayment plan must have the approval of the state or county medical society in the area in which it operates. The medical profession in the area must assume responsibility for the medical services included in the benefits. Plans must provide free choice of a qualified doctor of medicine and maintain the personal, confidential relationship between patient and physician. The plans must be organized and operated to provide the greatest possible benefits in medical care to the subscriber.

Medical care plans may be in terms of either cash indemnity or service units, with the understanding that benefits paid in cash are to be used to assist in paying the costs incurred for medical service. The standards also include provisions relative to the actuarial data that are required, systems of accounting, supervision by appropriate state authorities, and periodic checking and reporting of the progress of the plan to the Council.

Associated Medical Care Plans, Inc.

Coincidentally with the announcement of these standards of

(Continued on page 2, column 2)

J. C. SARGENT NAMED TO SPECIAL AMA COMMITTEE

Dr. James C. Sargent, Milwaukee, has been named by the Board of Trustees of the American Medical Association to serve as a member of the Committee on Military Medical Service, created on instruction of the House of Delegates. A meeting of the committee has been called for Friday, March 15, in Chicago, to confer with the Executive Committee of the Board of Trustees.

J. C. SARGENT

COUNCIL ON MSPR URGES COOPERATION WITH COMMITTEE HEADED BY H. KENT TENNEY

Within the next several months the physicians of Wisconsin will be asked to assist with a survey to determine to what extent existing state agencies are prepared to administer adequate child health programs, as opposed to federally-directed programs such as the "Pepper Bill".

Spearhead for the positive attack on further expansion of federal agencies interested in national health programs is the American Academy of Pediatrics, which has set aside funds for a national statistical survey being launched with at least the active cooperation of the Children's Bureau and the U. S. Public Health Service, according to Dr. H. Kent Tenney, Madison, who attended the last meeting of the Academy in Detroit for several days during January and was charged with the responsibility of carrying on the survey in Wisconsin.

Two-Fold Purpose of Survey

Describing the purpose of the study and the plan which will be followed in Wisconsin, Doctor Tenney said: "The purpose of this study is two-fold: (1) To show that no one formula such as the Pepper Bill will answer the needs in every state, and (2) to show that there are areas of our health programs which need expansion, and through wise utilization of federal funds by state agencies.

"It is our understanding that the Children's Bureau has agreed to accept the findings of this study as the basis on which they will formulate needs in the several states. Recommendations for the utilization of federal funds will be based on facts revealed by this study. It is essential that we in

(Continued on page 2, column 1)

STATE SURVEY—

(Continued from page 1)

Wisconsin make a comprehensive survey so we can base our arguments for state control on facts, not mere generalities."

Each MD Must Help

Doctor Tenney explained that data sheets will soon be distributed to all Wisconsin physicians and hospitals so that national statisticians in Washington employed by the American Academy of Pediatrics will have an opportunity of evaluating state needs and resources. The cooperation of all members of the State Medical Society is urged so that the Wisconsin study can be completed as soon as possible.

Approved By Council on MSPR

The entire project, as it relates to Wisconsin, was presented to the Council on Medical Service and Public Relations by Doctor Tenney on March 3. Approval was accorded the survey, and the Council recommended that the Secretary's office assist Doctor Tenney in the collection of the data needed.

Commenting on the survey during the course of the discussion by the Council on Medical Service and Public Relations, Dr. R. G. Arveson, chairman, said:

"For years we have talked in general terms about our ability to carry on adequate health programs in Wisconsin without federal direction, but we've been short on facts to back up our contentions. This is a wonderful opportunity to show the Children's Bureau and other Washington agencies concerned with health matters just what we can do with existing state funds, what federal funds are needed to develop our program in terms of recognized needs, and whether or not we have the personnel and administrative setup to carry on a program which is in keeping with needs for our particular state. The entire Council urges each physician to cooperate with Doctor Tenney and give immediate attention to the requests for information when they are received."

ANNUAL MEETING
October 7-8-9—Milwaukee
Headquarters at Hotel Schroeder
Make room reservations soon

AMA PROGRAM—

(Continued from page 1)

acceptance, there was organized, as a voluntary federation, an organization known as Associated Medical Care Plans, Inc. This independent association will include as members all plans that meet the minimum standard of the Council on Medical Service of the American Medical Association. The Associated Medical Care Plans will undertake to establish coordination and reciprocity among all of these plans so as to permit transference of subscribers from one plan to another and use of the benefits in any state in which a subscriber happens to be located. Under this method great industrial organizations with plants in various portions of the United States will be able to secure coverage for all of their employees. Moreover, it will be possible for the Veterans Administration, welfare and industrial groups as well as government agencies, to provide coverage for the people in any given area through a system of national enrollment. In addition, the Associated Medical Care Plans, Inc., will undertake research and the compilation of statistics on medical care, provide consultation and information services based on the records of existing plans and engage in a great campaign of public education as to the medical service plan movement under the auspices of state and county medical societies.

Division of Pre-Payment Medical Care Plans

The Board of Trustees of the American Medical Association also announced the establishment under its Council on Medical Service of a Division of Prepayment Medical Care Plans with a director and a staff who will administer the activities of the Council on Medical Service related to the promotion and development of medical care plans in all of the states.

In announcing its proposals for a nation-wide provision of sickness insurance on a mutual nonprofit basis, the Association through its President and the Board of Trustees authorizes the publication of its complete health program with the ten points, which include the development of services in the field of preventive medicine, maternal and child health, voluntary prepayment plans for protection against the costs of sickness, compensation for loss of wages due to illness, the care of the veteran, and the development of a high standard of housing, nutrition, clothing, and recreation. The American Medical Association last June through its Board of Trustees and Council on Medical Service announced a fourteen-point program to improve the health and medical care situation in the United States. In October, 1945, the interpretation of these fourteen points and methods of implementation were adopted by the Council on Medical Service. In December, 1945, the House of Delegates approved the whole program, suggested its rearrangement, and directed the Board of Trustees to keep the program constantly up to date so that it will stay at least even with and, if possible, a step ahead of the needs of the public.

With this in mind the Board of Trustees has adopted the following restatement of the fourteen point program, clarifying still further the position of the American Medical Association on some of these points and bringing into the program more definitely such matters as maternal and child welfare, medical research, the medical care of the veteran, and the part to be played by the voluntary health agencies.

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DANE COUNTY DOCTORS SURVEY EXTENT OF CHRONIC ILLNESS

In conjunction with the survey currently being conducted regarding the proposed new county institution for the chronically ill, long term convalescent, and the aged, the Dane County Medical Society is compiling a list of all people known to have such a physical difficulty. Through a questionnaire distributed among members of the society, the names of those patients who are not on public assistance or in institutions, but who are physically unable to care for themselves, are listed, with indications as to which ones would be likely to use a new county institution.

The names of persons receiving public assistance, to be secured from government agencies, will be added. With this pertinent information available, more accurate planning for the new institution should result.

The Wisconsin State Board of Vocational and Adult Education has developed quite a program for the handling of cases under the Barden–La Follette Act. The intent of this law is to provide vocational rehabilitation for any person having a physical handicap where vocational training, guidance, or placement would enhance the person's employability.

Medical care may be given to remove or reduce the employment handicap. Federal authorities estimate that there are nearly 200,000 Wisconsin citizens who have vocational handicaps, but they do not disclose how many of these would be eligible for physical restoration or how many need vocational training.

In the last six months of 1946, 756 physical examinations were given under supervision of the Wisconsin department at an average cost of $7.50. This would indicate that a normal year's experience might bring in 1,500 to 2,000 new cases with perhaps 25 per cent of them requiring physical restoration.

* * *

The Veterans Administration has many problems. How extensive they are may be understood from the fact that as of last January, there were over 79,500 veterans in VA hospitals. Of these, 12,000 were World War I veterans with service-connected disabilities, and another 37,500 veterans of World War I were hospitalized with non-service-connected disabilities. Of the 29,000 World War II veterans in VA hospitals, about a 50-50 ratio pertained as to service- and non-service-connected disabilities. A large number of veterans are hospitalized for observation.

* * *

It is rumored that the contribution system to the present Social Security system will require some considerable revision. Using standard actuarial methods for estimating future demands, it is claimed that the old-age reserve fund now shows a deficit of more than $16,000,000.

The State Department of Public Welfare through its Division of Public Assistance has made a small pilot study to determine the approximate amount of annual payments to physicians and hospitals through public assistance agencies.

Excluding direct subsidies for county hospitals and the Wisconsin General Hospital, the department estimates that over three million dollars was paid in 1945 to Wisconsin physicians and hospitals through these agencies.

* * *

Edwin E. Witte of War Labor Board and Social Security fame is expected to return to Wisconsin and resume his staff affiliation with the University of Wisconsin.

Milwaukee Station Now Carries "March of Medicine"

Madison, Feb. 28—Radio Station WEMP, Milwaukee, has been added recently to the group of stations which broadcast the weekly transcribed series, THE MARCH OF MEDICINE, sponsored by the State Medical Society of Wisconsin.

The series, which is recommended by the Wisconsin Joint Committee for Better Radio Listening, is under the direction of Dr. Llewellyn R. Cole. Doctor Cole is director of student health at the University of Wisconsin, on leave during the current semester. Recently guest speakers have been included to talk on special subjects. Drs. C. N. Neupert, state health officer; William J. Bleckwenn, who served as Consultant in neuropsychiatry to the Sixth Service Command; William D. Stovall, director of the State Laboratory of Hygiene; and others are among those featured in the series.

The stations which carry the broadcasts as a public service feature are:

Ashland	WATW	1400 kc.	Saturday	8:15 a. m.
Eau Claire	WEAU	790	Wednesday	4:15 p. m.
Green Bay	WTAQ	1360	Friday	3:45 p. m.
Ironwood, Mich.	WJMS	1450	Saturday	8:15 a. m.
La Crosse	WKBH	1410	Thursday	4:00 p. m.
Madison	WIBA	1310	Saturday	9:45 a. m.
Manitowoc	WOMT	1240	Saturday	10:45 a. m.
Marinette	WMAM	570	Thursday	4:00 p. m.
Marquette, Mich.	WDMJ	1340	Saturday	8:15 a. m.
Medford	WIGM	1490	Thursday	11:00 a. m.
Milwaukee	WEMP	1340	Saturday	11:30 a. m.
Rice Lake	WJMC	1240	Monday	2:45 p. m.
Stevens Point	WLBL	930	Monday	11:30 a. m.
Superior	WDSM	1230	Saturday	10:00 a. m.

BACK FROM THE WARS, DOCTOR?

If you have just returned from the Armed Services, we are reminding you to reinstate your TIME Accident & Health policy.

Physicians prefer TIME's professional policy, for it is logical, broad coverage at a reasonable premium.

The Time Insurance Company

213 W. Wisconsin Ave.
Milwaukee 3, Wis.

Basic Principles of Industrial Health Program Developed by SMS and State Board of Health

Plans Made to Enlist Aid of Industrial Leaders in Having Program Used in State Plants

Madison—An industrial health program, which it is hoped will be generally adopted by Wisconsin industries in cooperation with county medical societies, has been studied and the groundwork for it has been prepared by the Committee on Industrial Health, working for the past several months under the chairmanship of Dr. D. E. Dorchester of Sturgeon Bay.

Special Study on Nurses

Meeting the latter part of January, the committee gave special study to the outline of qualifications for various types of industrial nursing positions, description of duties, and recommended administrative policies for industrial nursing services, as prepared by the Industrial Nurses Section of the Wisconsin State Nurses Association and presented to the committee by Miss Catherine Chambers, R. N., of the Bureau of Industrial Hygiene, State Board of Health, and temporary chairman of the section. The comprehensive classification of types of positions, and specific outline of desirable qualifications, duties, and administrative policies were approved by the committee after minor revisions were made.

Stresses Cooperation of MDs

Dr. Paul Brehm, director of the Bureau of Industrial Hygiene, who met with the committee in January, stressed the need to have general acceptance of basic principles indicating the relationship of the physician to the entire industrial health program. He presented for study and modification a suggested draft of principles indicating the necessity of having county medical societies assume a prominent role in the development of industrial health programs, as well as the relationship of the individual plant physician to other physicians in the community.

"Kenosha County physicians have given us a good start on a sound industrial health program," said Doctor Brehm, referring to the plan carried out at the Snap-on-Tools Corporation, Kenosha, "and we feel sure many other industries in the state will follow the lead of medicine if we come forward with a well-thought-out plan which will convince top management that an industrial health program will be good business as well as making employment in their plant more attractive to workers."

Reviewed by A. M. A.

All of the material thus far developed by the committee or given its approval has been submitted to the Council on Industrial Health of the A. M. A. for review and coordination with accepted principles adopted by the national organization for the entire country.

Speaking of the development of a program on a state-wide level, Doctor Dorchester said that "top management will accept our ideas if they meet the 'dollar and cents' standards of Wisconsin industrial leaders." Elaborating on his remarks, Doctor Dorchester said: "Industrial leaders of the state cannot be approached on the idea of employing nurses and special medical care under the idealism of paternalism. We feel confident, (and many industrial leaders in the state agree with us) that a well-planned industrial health program, worked out in cooperation with the county medical society involved, can result in better employe efficiency, with resultant profits to management.

"If this program is carefully developed in Wisconsin, we can enjoy a fine public relationship between medicine, management, and labor. If we do a good job in this area of medical care, we can be sure that both management and labor will look with favor upon our resistance to federalized health programs. If we fail to give management and labor the medical leadership required we are just digging the grave of American medicine a little deeper."

CARE OF TUBERCULOUS, PSYCHIATRIC CASES IN GENERAL HOSPITALS PREDICTED BEFORE AHA

Chicago—Expansion of services of the large general hospital to include tuberculosis and nervous and mental care may well take place in the future, suggested Arthur C. Bachmeyer, M. D., at the Midyear Conference Feb. 8 and 9 of the American Hospital Association. The director of study of the Commission on Hospital Care, an independent public service committee studying hospital facilities in the United States and initiated by the Association, Doctor Bachmeyer spoke before officers of hospital organizations of the United States and Canada. The conference was held in Chicago.

Discussions of relationships of the general hospital to all types of health care bring the following considerations to the fore, Doctor Bachmeyer told the conferees:

(1) The advisability of constructing new tuberculosis facilities adjacent to and operated in conjunction with large general hospitals;

(2) The provision of facilities in large general hospitals for diagnosis of nervous and mental patients, and for treatment of those patients not in need of long-term institutional care; and

(3) The feasibility of expanding the functions of special communicable disease hospitals now operated by cities, towns, and villages to include all types of illness.

The possibility of the maintenance of nursing schools by large institutions only, which would affiliate for rural hospital experience with hospitals in smaller communities; improved hospital care for negroes; and the computation of the need for hospital beds in local or statewide areas based upon the ratio between the death rate and the days of hospital care, were other proposals related to the group by Doctor Bachmeyer.

It is expected that the Commission's report will be published shortly thereafter.

STATE BOARD EXPRESSES VIEWS ON FEDERAL BILLS

APPROVES HILL-BURTON BILL ANALYZES WAGNER BILL FEATURES

Unqualified approval of the Hill–Burton bill (S-191), recently passed by the Senate and referred to the House, was given by the State Board of Health at its February meeting. "This bill has much merit in that it provides for release of funds, only after adequate study of the state of hospital and health center construction needs, assures reasonable distribution of available funds, and safeguards state responsibility and control. If passed as it now stands, it would appear to be in the interest of public health."

On the revised Wagner–Murray–Dingell bill (S-1606) the board approved Title I–Part A, Public Health Services, "inasmuch as this section seems designed to implement existing programs and to retain in full state direction of activities planned on state needs and state problems."

Child Health Services

With reference to Title I–Part B, Maternal and Child Health Services, of the same bill, the board felt that "passage of this section would tend to decrease individual and community initiative and responsibility. The board is of the opinion that all parts of any legislation dealing with training and research should be carefully guarded to avoid any federalization of medical education or research."

The board disapproved Title II —Prepaid Personal Health Service Benefits, on the grounds that it "involves principles which are in many ways diametrically opposed to basic forms of procedure fundamental to a republic. There is no guarantee that by changing procedures for medical care under which the medical profession has already made an outstanding record of accomplishment it will either assure better care at a lesser cost to the American people or that such change would better serve the interests of public health."

The board stated that it would not support Bill S-1318 (Pepper bill.) "Although the board recognizes that many groups need some help in distributing the cost of medical care, it cannot be in accord with any bill that takes away all individual responsibility for providing their own care. The Pepper bill as drawn up not only removes individual responsibility, but masks the cost of providing care."

Occasion for officially recording the stand of the State Board of Health on these important federal health bills was a request from the executive committee of the State and Territorial Health Officers Association, addressed to state boards of each of the states and territories, asking for the opinion of the group.

MEDICAL PRACTICE ACT VIOLATORS ARRAIGNED

River Falls—After an investigation of his activities by the Wisconsin State Board of Medical Examiners, a complaint was made and a warrant was issued against Oscar Earl Maule, Route 1, Greenleaf, Wisconsin, charging him with a violation of the Medical Practice Act. Two counts were alleged in the complaint, the first charging the defendant with treating the sick without a basic science certificate, and the second charging him with practicing medicine without a license.

When arraigned, the defendant offered to plead guilty to the first charge provided the second charge was dismissed. After conferring with the Attorney for the State Board of Medical Examiners, the District Attorney disposed of the case in this manner, and the Municipal Judge fined the defendant $100 and the costs of the proceedings, which he paid.

The only license of any kind which Maule held at the time of his arrest was a transient merchant's license issued by the State of Michigan. The investigation showed that he was making diagnosis and treating his patients with various herb remedies which he compounded himself.

Unauthorized Use of Title "Doctor"

A licensed chiropractor, George C. Yeomans, Ripon, Wisconsin, was arrested recently on the complaint of the Attorney for the State Board of Medical Examiners, charged with the unauthorized use of the title "Doctor" and with practicing medicine without a license.

The defendant entered pleas of not guilty to both charges when arraigned in Municipal Court at Ripon, and the case has not been tried as yet.

Fifteen Attendant Applicants Examined

Madison, Feb. 26—Fifteen applicants for licensure as medical attendants were examined by the State Board of Nurse Examiners today. Of this number, fourteen passed satisfactorily. Sixteen requests for examination had been previously approved. Applicants ranged in age from twenty to fifty-nine years.

Many of the women applying have previously been enrolled in schools of nursing, and dropped out for acceptable reasons; others have already been performing the duties of attendants.

As yet no applications for licensure by reciprocity have been received.

The next examination is tentatively scheduled for October, just preceding the nurses' examination. However, if the number of applications warrants an earlier examination, one may be scheduled preceding the nurses' examination to be held in June.

WOMAN'S CLUB OPPOSES WAGNER–DINGELL BILL

Clinton, Wis.—Socialized medicine and the Wagner–Murray–Dingell bill were the topics of discussion at a "Town Meeting" of the Twentieth Century Club, held here February 12. Speakers for the evening represented the medical and dental professions with the program taking the form of a round-table discussion.

It was voted to send a letter opposing the bill, to be signed by all club members, to Representative L. H. Smith. This is in line with the stand of the Federated Women's Clubs, which oppose the proposed medical insurance bill.

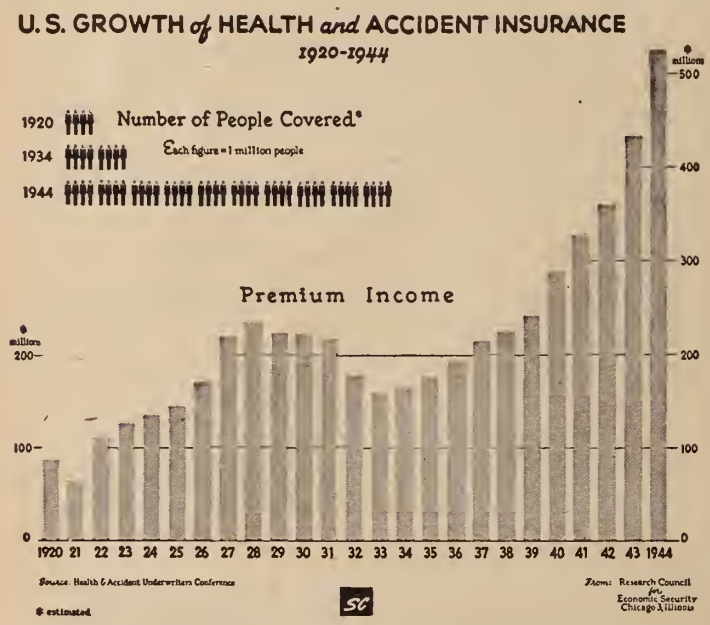
Dates For Orthopedic Clinics Are Announced

Madison—Orthopedic field clinics to be held in the next four months throughout the state have been announced by the Bureau for Handicapped Children of the State Department of Public Instruction.

The clinics, conducted by the Crippled Children Division for persons under twenty-one years of age who come within the state's definition of a crippled child, will be held as follows: Racine, March 29; Green Bay, April 5; Eau Claire, April 11 and 12; Sheboygan, April 26; Superior, May 3; Appleton, May 10; La Crosse, May 17; Kenosha, May 22; Chippewa Falls, June 21; and Janesville, June 28.

Referrals to the clinic made by the family physician are preferred, but arrangements *may* be made by writing the Bureau. Referral forms should be requested in advance of the clinic date, and families will be notified of the exact time of their appointment.

Parents and physicians are invited to attend the clinic with the child; the Bureau should be notified in advance if the public health nurse feels that the child referred to the clinic for orthopedic reasons is also in need of other services.



More than 40,000,000 Americans are estimated to enjoy health and accident insurance protection today, as shown by the above chart. The chart also shows that the rate of growth in number of persons protected by health and accident insurance policies has been much more rapid than the rate of growth in premium income. The reason is that health and accident and hospitalization protection has been made more generally available to working people through the rapid development of group insurance. The number of employers who are offering their employees group protection grows larger every day Some employers pay the entire cost, and other plans are based upon sharing the cost between employer and employee, so that the latter is protected at exceptionally low expense. Even where the full cost is borne by employees, the low rate is not burdensome.

Despite the dynamic growth in the number already covered, further rapid growth may be reasonably expected in the immediate future. This makes it evident that the percentage of population protected is rapidly approaching a figure which will refute completely the argument of advocates of compulsory governmental programs that insurance companies are not reaching the people who really need their protection.

Minnesota Medical School Plans 100 Bed Heart Hospital

Cost Underwritten By Lay Charity Organization

Minneapolis—Construction of a $325,000 hospital with a capacity of 100 beds, as part of the University of Minnesota Medical School, to treat the victims of heart disease and study its prevention and cure, is being sponsored by the Variety Club of the Northwest, a charitable organization of men in show business, who have undertaken the task of raising the money needed and have also pledged $25,000 a year from their treasury to finance heart cases in the hospital where family funds are not available. Slated to be the first hospital in the United States devoted solely to the study of and research on the causes, treatment, and care of heart disease, the "heart hospital" will be completely equipped with the most modern accommodations and equipment to treat patients with rheumatic disease, it will be a clinic available for doctors throughout the Northwest to study the disease, and it will be an out-patient clinic in which ambulatory patients from the entire Northwest can be examined and obtain diagnoses.

Low Amount For Heart Research

While 536,745 deaths resulted from heart disease in 1940, as compared to 1,026 from infantile paralysis, the comparative amounts spent on research per death were: 17¢ for heart disease and $525 for infantile paralysis. "In order to attack rheumatic fever efficiently," said Dr. M. J. Shapiro of the University of Minnesota Medical School, "it is most important that we have available an institution, a heart hospital, where the acute and most important phase of this disease may be treated and studied. Such a hospital will make it possible to establish a central headquarters where children with rheumatic fever not only from Minneapolis but throughout the Northwest can be treated."

SPRING CLINICS

June 5—Wisconsin Rapids
June 6—Fond du Lac
June 7—Monroe
Watch for Details in April Journal

SURPLUS BLOOD PLASMA SHIPMENTS BEGUN

Madison—Distribution of the free dried blood plasma made available to Wisconsin by the American Red Cross from surplus Army and Navy stocks is now under way on the basis of a plan agreed upon by doctors, hospitals, and the State Board of Health recently.

Because the blood was voluntarily contributed to the armed forces the Red Cross has stipulated that it be utilized to the best advantage of the American people and therefore no charge is to be made for the plasma. Physicians and hospitals will charge only for administering it.

Two carloads of dried blood plasma, containing 7,800 units, have been received by the State Board of Health and are stored in the State Laboratory of Hygiene, which will have charge of shipping. The commercial value of each unit is $18.

The plan of distribution approved by representatives of the State Medical Society, Wisconsin Hospital Association, and the State Board of Health calls for shipment to each general hospital of one unit of plasma for every four beds, and one unit for every practicing physician. Dr. W. D. Stovall, director of the State Laboratory of Hygiene, has written to each hospital asking it to act as the local distributing agent for physicians, and has written to each physician, requesting him to call for his unit at the local hospital.

Hospitals have been instructed, when their present supply runs low, to request additional units from the State Laboratory of Hygiene; physicians are also to apply there for replacement units.

In Milwaukee County, the entire allotment has been shipped to the Medical Society of Milwaukee County, which will distribute it both to physicians and to hospitals on the above-outlined basis. In counties which have no hospitals the plasma will be sent directly to the physicians.

Enough dried blood plasma has been returned by the Army and Navy to supply ordinary civilian needs for an estimated two years. By that time the State Board of Health proposes to have its statewide blood bank in operation. Donors will supply blood through Red Cross chapters and the State Laboratory of Hygiene will process, package, and distribute the plasma.

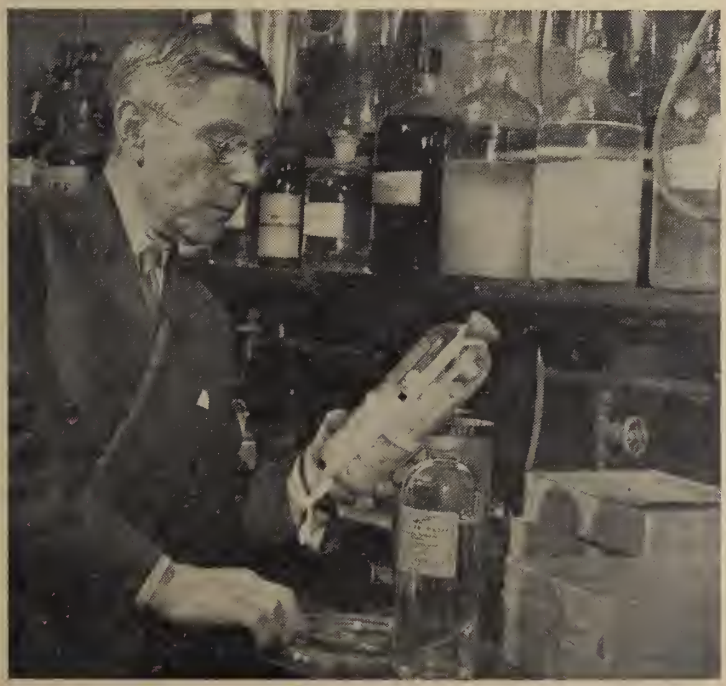


Photo Courtesy Wisconsin State Journal

W. D. Stovall, Madison, is in Charge of the Wisconsin Plasma Program

STATE BOARD OF HEALTH TO SEEK $500,000 FOR NEW LAB FACILITIES

Madison—At its March meeting the State Board of Health will given intensive study to plans for the proposed new State Laboratory of Hygiene to be located in Madison, which which it intends to ask the 1947 Legislature to appropriate approximately $500,000 for construction. Dr. W. D. Stovall, director, recently appeared before representatives of leading organizations in the state meeting in Madison, to outline the need for the new building.

In the last twenty-five years scientific research has added much new knowledge, the application of which requires laboratory methods. The facility in the laboratory has not kept pace with these advances so that the development is, and has been for a number of years, stationary. This lag in progress has become so acute that unless we can embark now on a program of laboratory development, the State Board of Health will be without modern laboratory facility in its program of disease control.

The figures below give some idea of the increase in the load of work and the lag in the development of needed facility.

1. Total number of specimens examined. Increase in technical work—. Total number of specimens by years.
   (a) July 1924 to July 1925_ 42,709
   (b) Jan. 1934 to Dec. 1934_ 85,597
   (c) Jan. 1944 to Dec. 1944_114,200
2. Space occupied
   A. 1928

	Square Feet
Total laboratory working area	6,303.4
Total storage	1,206.
Total animal space (stock)	302.

   B. 1945
   Same as above.
3. Needs for expansion.
   A. A laboratory building for the Central Laboratory.
   B. Increase in staff.
   C. Increase in equipment and type of apparatus.

Applicants For Licensure By Reciprocity Examined

Twenty-six applicants for licensure by reciprocity to practice medicine in Wisconsin were examined by the State Board of Medical Examiners in Madison on Tuesday, March 5.

AMA PROGRAM—

(Continued from page 2)

1. The American Medical Association urges a minimum standard of nutrition, housing, clothing, and recreation as fundamental to good health and as an objective to be achieved in any suitable health program. The responsibility for attainment of this standard should be placed as far as. possible on the individual, but the application of community effort, compatible with the maintenance of free enterprise, should be encouraged with governmental aid where needed.

2. The provision of preventive medical services through professionally competent health departments with sufficient staff and equipment to meet community needs is recognized as essential in a health program. The principle of federal aid through provision of funds or personnel is recognized with the understanding that local areas shall control their own agencies as has been established in the field of education. Health departments should not assume the care of the sick as a function since administration of medical care under such auspices tends to a deterioration in the quality of the service rendered. Medical care to those unable to provide for themselves is best administered by local and private agencies with the aid of public funds when needed. This program for national health should include the administration of medical care including hospitalization to all those needing it but unable to pay, such medical care to be provided preferably by a physician of the patient's choice with funds provided by local agencies with the assistance of federal funds when necessary.

3. The procedures established by modern medicine for advice to the prospective mother and for adequate care in childbirth should be made available to all at a price that they can afford to pay. When local funds are lacking for the care of those unable to pay, federal aid should be supplied with the funds administered through local or state agencies.

4. The child should have throughout infancy proper attention including scientific nutrition, immunization against preventable disease, and other services included in infant welfare. Such services are best supplied by personal contact between the mother and the individual physician but may be provided through child care and infant welfare stations administered under local auspices with support by tax funds whenever the need can be shown.

5. The provision of health and diagnostic centers and hospitals necessary to community needs is an essential of good medical care. Such facilities are preferably supplied by local agencies, including the community, church, and trade agencies which have been responsible for the fine development of facilities for medical care in most American communities up to this time. Where such facilities are unavailable and cannot be supplied through local or state agencies, the federal government may aid, preferably under a plan which requires that the need be shown and that the community prove its ability to maintain such institutions once they are established. (Hill–Burton bill)

6. A program for medical care within the American system of individual initiative and freedom of enterprise includes the establishment of voluntary nonprofit prepayment plans for the costs of hospitalization (such as the Blue Cross plans) and voluntary nonprofit prepayment plans for medical care (such as those developed by many state and county medical societies). The principles of such insurance contracts should be acceptable to the Council on Medical Service of the American Medical Association and to the authoritative bodies of state medical associations. The evolution of voluntary prepayment insurance against the costs of sickness admits also the utilization of private sickness insurance plans which comply with state regulatory statutes and meet the standards of the Council on Medical Service of the American Medical Association.

7. A program for national health should include the administration of medical care, including hospitalization, to all veterans, such medical care to be provided preferably by a physician of the veteran's choice with payment by the Veterans Administration through a plan mutually agreed on between the state medical association and the Veterans Administration.

A. E. RECTOR RE-NAMED TO STATE HEALTH BOARD

Dr. A. E. Rector, Appleton, was reappointed January 1 as a member of the State Board of Health for another seven-year term, subject to confirmation by the Senate.

A. E. Rector

8. Research for the advancement of medical science is fundamental in any national health program. The inclusion of medical research in a National Science Foundation, such as proposed in pending federal legislation, is endorsed.

9. The services rendered by volunteer philanthropic health agencies such as the American Cancer Society, the National Tuberculosis Association, the National Foundation for Infantile Paralysis, Inc., and by philanthropic agencies such as the Commonwealth Fund and the Rockefeller Foundation, and similar bodies have been of vast benefit to the American people and are a natural outgrowth of the system of free enterprise and democracy that prevails in the United States. Their participation in a national health program should be encouraged and the growth of such agencies, when properly administered, should be commended.

10. Fundamental to the promotion of the public health and alleviation of illness are widespread education in the field of health and the widest possible dissemination of information regarding the prevention of disease and its treatment by authoritative agencies. Health education should be considered a necessary function of all departments of public health, medical associations, and school authorities.

The
MEDICAL FORUM

The Wisconsin Medical Journal April, 1946

JAY KETCHUM TO HEAD NEW AMA DIVISION

New York Health Plan Shelved After Fifteen Months' Study

Commission on Medical Care Unable to Recommend Plan

New York, N. Y., February 15—Inability to recommend any plan for medical care and hospital insurance without further experience in the field was expressed by the majority report of the Commission on Medical Care, appointed by the New York Legislature in 1944 to study the question of compulsory medical care. In reporting to Governor Dewey, the Commission made the following recommendations: (1) Adequate medical care should be made more readily available to all residents of the state, (2) The persons to be benefited should pay a material part of the cost, (3) There should be freedom of choice of doctor by patient and of patient by doctor, (4) There should be as little government interference in the practice of medicine as is consistent with proper standards of medical service, and (5) Good voluntary medical and hospital insurance plans should be encouraged.

The devising of a plan to make medical care more available to all classes of people in the State of New York was originally defined by the governor as the task of the group. Though the insurance or prepayment principle soon appeared to be the one which could best accomplish the objective, the Commission in its report states that it "is not prepared to recommend to the Legislature any plan for medical care insurance and hospital insurance financed on a compulsory basis."

"A comprehensive plan for medical care," the report continues, "includes hospitalization; physician's care at home, in the office, and in the hospital; nursing care; diagnostic services; and limited dental care. The cost of this type of plan covering every resident of the state has been variously estimated, but it would probably be at least $400,000,000 a year. This would mean a cost of at least $30 per capita.

"The Commission is of the opinion that this sum represents too great an expenditure to be imposed on the people of the state, either directly or indirectly through governmental authority, until there has been more experience in the field of medical and hospital insurance.

"There would be serious difficulties in administering medical care to thirteen million people and avoiding abuses and deterioration in the quality of service. Furthermore, the facilities in the state with respect to medical, dental, nursing, and hospital care would need to be greatly expanded.

(Continued on page 8, column 2)

WAGE LOSS INSURANCE IN NEW CALIFORNIA LAW

Unemployment Compensation Act To Include Disability Benefits

Compensation for wage loss for individuals unemployed due to sickness or injury is now granted in California by an amendment to the existing Unemployment Insurance Act, establishing a system of unemployment compensation disability benefit payments, passed by the California Legislature February 14. The new law expressly encourages voluntary efforts in lieu of the compulsory plan.

The total amount of compensation and the weekly benefit amount payable to eligible individuals is to be computed in accordance with the provisions of the present unemployment compensation law. Although eligible individuals may collect both benefits in the same

(Continued on page 4, column 3)

WILL DIRECT AMA DIVISION ON PREPAYMENT MEDICAL CARE

Mr. Jay Ketchum, Executive Vice-President of Michigan Medical Service, has been appointed Director of the newly created Division of Prepayment Medical Care Plans, effective March 15, according to an announcement by the Executive Committee of the Board of Trustees of the AMA.

Members have been named to an Advisory Committee, representing medical care plans and their associations, recommended by the Council on Medical Service and Public Relations to advise the Director and the Council on methods of implementing the program. This Committee, on which Wisconsin is represented by Mr. Charles H. Crownhart, includes Mr. Ketchum; Dr. F. Feierabend, Missouri; Dr. Herbert Bauckus, New York; and Mr. William Bowman, California.

Assisting in developing medical care plans, increasing the number of persons covered by presently existing plans, and facilitating reciprocity among them, will be the duties of the new Division of Prepayment Medical Care Plans, together with its director and staff, to be assisted by the Advisory Committee, state medical societies, and the Associated Medical Care Plans, Inc.

Standards of Acceptance Announced

Stating that the utilization of the prepayment method to help spread medical and surgical costs is of primary importance in its function of developing plans affecting the distribution of medical care, the Council on Medical Service and Public Relations has announced Standards of Acceptance for medical care plans. The acceptance of a plan and the use of the seal of the Council signify that

(Continued on page 2, column 2)

OTIS REPORTS PROGRESS IN COLLECTION OF WISCONSIN HOSPITAL SURVEY REPORTS

Hospital Care Commission To Aid in Tabulation

Madison, March 25—The questionnaires currently being completed for Wisconsin's Hospital Survey may all be collected by June 1, according to a statement made today by Mr. Vincent F. Otis, director of the survey. These "Hospital Schedules of Information," mailed on October 20, 1945, to 425 hospitals and related institutions, were to have been completed by December 31. Representatives of the State Board of Health are now in the field visiting each institution and examining the reports for accuracy and completeness of information; assistance in this field work is being given by nine state District Health Offices, the Department of Public Welfare, for mental institutions, and the Tuberculosis Division of the Board of Health, for the sanitoria.

When collected and tabulated, the information in these schedules will constitute an inventory of hospital facilities in the state, needed to enable the Board of Health and the Hospital Advisory Committee to draw conclusions and make intelligent recommendations for additional facilities. This tabulation, to be made by the Commission on Hospital Care, will be used in conjunction with a study of the economic and social factors involved in the complete picture of hospital needs, a time-consuming but very important phase of the survey.

Economic and Social Factors to be Studied

The collected information, and this further study will help answer the following questions about hospitals, as outlined in a Study Manual published by the Commission on Hospital Care to aid those in charge of the state surveys:

(1) How many people are needed for a hospital community? How far can and will people go to a hospital?

(2) What size and type of hospital or medical service unit is needed for each service area or community?

(3) How many beds are needed in the different areas and under different conditions?

V. F. Otis

(4) How do the health conditions of an area affect the need for hospitals and hospital beds by types?

(5) Which small hospital communities shall be grouped with certain larger hospital centers to

(Continued on page 6, column 1)

KETCHUM NAMED—

(Continued from page 1)

the plan meets the following requirements:

Local Approval: (1) The prepayment plan must have the approval of the state medical association—or if local, of the county medical society—in whose area it operates.

Professional Control: (2) The medical profession should assume responsibility for the medical services included in the benefits; the medical profession is qualified legally and by education to accept responsibility for the character of the medical services rendered.

Arbitration: (3) Provision should be made for a medical director acceptable to the county or state medical society, or a committee appointed by either of these groups, to adjust difficulties and complaints. The medical director or committee members may be paid on a per diem basis for the time involved in handling such matters.

Free Choice of Physician: (4) There should be no regulation which restricts free choice of a qualified doctor of medicine in the locality covered by the plan who is willing to give service under the conditions established.

Patient–Physician Relationship: (5) The method of giving the service must retain the personal, confidential relationship between the patient and the physician.

(6) The plan should be organized and operated to provide the greatest possible benefits in medical care to the subscriber. Honesty of purpose and sincere consideration of mutual interests on the part of the subscribers, the physicians, and the plans are presupposed as necessary considerations for successful operation.

(7) The dues from subscribers through premium rates should be adequate to provide for the benefits offered and the risks involved.

In determining such factors the Council will utilize the experience of those plans that are and have been operating successfully, but will not discourage experiments in other types of coverage provided such experiments are limited in scope and capable of scientific evaluations.

Statement of Benefits: (8) These benefits may be in terms of cash indemnity for service units. Where benefits are paid in cash to the subscriber it must be clearly stated that these benefits are for the purpose of assisting in paying the charges incurred for medical service and do not necessarily cover the entire cost of medical service, except under specified conditions.

(9) Subscribers' contracts must state clearly the benefits and conditions under which medical ser-

(Continued on page 8, column 1)

More Aged Workers

According to Social Security tabulations, only one-third of the aged workers eligible for benefits took them in 1945; the wartime boom in jobs lifted the level of employment of persons 65 and over from 1.9 million in March, 1940, to 2.7 million in the summer of 1943. The number receiving payments in December, 1943, showed a decrease of 3.6 per cent from December, 1942; this is important because the number of persons 65 or over increases by 200,000 annually.

The growing power of governmental administrative agencies in socio-economic legislation is becoming increasingly important. Many have become aware of the activities of the Social Security Board in connection with proposals for federalized and socialized medicine.

Now agents from the Federal Security Agency, the departments of labor and agriculture, as well as the United States Public Health Service, are entering the picture. It is said that these agencies were not only participants in a so-called "Health Workers Conference" held in St. Paul recently, but had a hand in shaping the recommendations that were issued by a group of about one hundred farm and labor representatives from seven northcentral areas.

According to rumor, the president of the Farmers Union met with Surgeon General Parran in 1945 to plan the conference intended as a sort of "pilot" effort. The one hundred delegates were present at the four-day conference and were graduated as "technical" consultants to carry the ball back home.

Subjects discussed, it is said, included general public health efforts in rural communities, housing and sanitation, safety, and similar matters.

In the field of insurance for the costs of medical care, the conference held it imperative to secure the passage of compulsory sickness insurance as a federal program. Voluntary plans, while given a pat for developing experience and patterns, were soundly condemned for alleged inadequacies.

* * *

It appears that the support being given by Congressman A. L. Miller, himself a Nebraska physician, to the A. M. A. proposal that there be a secretary of Cabinet rank in a Department of National Health, is producing interest in the plan.

Congressman Miller introduced H. R. 1391 to implement this proposal. He pointed out that there are at least thirty-two different federal agencies dealing with various phases of health. There are twelve of these in the Federal Agency alone.

* * *

The Detroit Blue Cross hospital dispute is like Joseph's coat. Apparently there is developing a discriminatory rate policy under which so-called Blue Cross patients get a break at the expense of those without this brand of insurance. The Detroit Free Press reports that one Michigan Hospital received $7,500 less from Blue Cross patients than paid for the same facilities by uninsured patients. Many students of the hospitalization insurance methods wonder what this means with reference to the soundness of statistical reports in this field.

* * *

Wisconsin is not the only state that is working through the agencies of commercial insurance carriers in the field of voluntary prepayment medical care insurance. Illinois already has an active program in that field. And considerable interest is developing in California where it has been suggested by the medical profession's leadership that medical, surgical, and hospital services be provided through Blue Cross and the physician's service, with insurance companies providing group life and cash indemnity for loss of time during illness and injury—the whole to be sold as a package by the insurance carriers themselves.

* * *

The State Board of Optometry is attempting to standardize the use of the title "doctor" by Wisconsin optometrists, although legal authorities in Wisconsin have held that its use is denied them under the law in this state. But the board is suggesting that they use the phrase "Doctor of Optometry" following their name, or "O. D., Optometrist." The board agrees that it sees "no reason why any optometrist should want to flount his name in public as Doctor John Jones, Optometrist, when John Jones, Doctor of Optometry so clearly and unquestionably designates him as a qualified refractionist."

* * *

Here's a departure from the usual material in this column. And

(Continued on page 5, column 3)

OUR AGING POPULATION

The population of the United States is gradually aging. From a total of 6.6 million in 1930, the number of people 65 and over is increasing and will reach 22 million in 1980, according to calculations of the Census Bureau. Thus the percentage of aged people will more than triple in this period.

According to the 1940 Census, 7.3 per cent of the population of the United States were 65 years of age or older, as compared with 5.4 per cent in 1930, and 4.1 per cent in 1900. In Wisconsin, these percentages were: 7.4 for 1940, 5.4 for 1930, and 4.95 in 1900.

A survey of some of the "older" counties in Wisconsin, contrasting with the national figure of 7.3 per cent over 65, shows: Rock, 8.7; St. Croix, 9.6; Pierce, 10.1; and Sauk, 10.5 per cent.

POLICYHOLDER NO. 24

The oldest accident and health policy in force in the United States is that of August Ranis of La Crosse, Wisconsin.

This policy, like thousands of other TIME policies, is kept in force year after year because it meets the need and gives satisfaction.

The Time Insurance Company

213 W. Wisconsin Ave.
Milwaukee 3, Wis.

Approved Hospitals for Vet Training Announced by Advisory Committee

Policy for Approval of Schools Outlined

Madison, March 5—Announcement is made today of those Wisconsin hospitals and institutions which have been approved for training veterans in internships and residencies, and as x-ray and clinical laboratory technicians, by action of the Governor's Educational Advisory Committee, meeting in regular session.

A statement of policy, adopted by the committee, outlining rules governing the approval of educational institutions and courses to be available to veterans, included these provisions, among others:

(1) Schools under the jurisdiction of the State Board of Health, such as schools of mortuary science, cosmetology, massage and hydrotherapy, etc., are approved if acceptable to the State Board of Health.

(2) When training on the job is for one year or more the place of employment designated as "approved" by the Apprenticeship Division of the Industrial Commission is approved.

(3) No institution shall use such approval in its advertising or for recruiting students. Any approved educational or training institution should be limited in its advertising to the statement "Approved under the G. I. Bill of Rights." Any institution violating this provision will be removed from the approved list.

Headed by Dean Fred Holt, Director of Public Service at the University, the committee is composed of: Walter B. Senty, Department of Public Instruction, secretary; John Callahan, Superintendent of Public Instruction; Edgar G. Doudna, Secretary, Normal School Regents Board; Father Brooks, President, Marquette University; Colonel Leo Levenick, Director, Wisconsin Department of Veterans Affairs; Walter F. Simon, Director, Apprenticeship Division, Industrial Commission; and C. L. Greiber, Department of Adult and Vocational Education. A representative from the Veterans Administration serves as an associate member.

The complete list of hospitals and institutions approved for internships, residencies, and technician training follows:

Intern Training and Mixed Residencies

St. Elizabeth Hospital, Appleton; Luther Hospital, Eau Claire; St. Agnes Hospital, Fond du Lac; St. Francis Hospital, La Crosse; Madion General Hospital, Methodist Hospital, St. Mary's Hospital, State of Wisconsin General Hospital, Madison; St. Joseph's Hospital, Marshfield; Columbia Hospital, Evangelical Deaconess Hospital, Milwaukee County Hospital, Milwaukee Hospital, Misericordia Hospital, Mount Sinai Hospital, St. Joseph's Hospital, St. Luke's Hospital, St. Michael's Hospital, St. Mary's Hospital, Milwaukee; St. Mary's Hospital, Racine.

Specialized Residencies

Anesthesiology: State of Wisconsin General Hospital, Madison; Columbia Hospital, Milwaukee. Medicine: State of Wisconsin General Hospital, Madison; Columbia Hospital, Milwaukee County Hospital, St. Joseph's Hospital, Milwaukee. Mixed: Mercy Hospital, Janesville; La Crosse Luther Hospital, La Crosse; St. Mary's Hospital, Superior. Obstetrics and Gynecology: State of Wisconsin General Hospital, Madison; Milwaukee County Hospital, Milwaukee. Ophthalmology and Otolaryngology: State of Wisconsin General Hospital, Madison; Milwaukee County Hospital, Milwaukee. Orthopedic Surgery: State of Wisconsin General Hospital, Madison; Milwaukee County Hospital, Milwaukee. Pathology: State of Wisconsin General Hospital, Madison; Columbia Hospital, Milwaukee County Hospital, St. Joseph's Hospital, Milwaukee. Pediatrics: State of Wisconsin General Hospital, Madison; Milwaukee Children's Hospital, Milwaukee County Hospital, Milwaukee. Psychiatry: State of Wisconsin General Hospital, Madison; Milwaukee County Hospital for Mental Diseases, Milwaukee; Milwaukee Sanitarium, Wauwatosa. Radiology: State of Wisconsin General Hospital, Madison; Columbia Hospital, Milwaukee. Surgery: State of Wisconsin General Hospital, Madison; Columbia Hospital, Milwaukee Children's Hospital, Milwaukee County Hospital, St. Joseph's Hospital, St. Luke's Hospital, St. Mary's Hospital, Milwaukee. Thoracic Surgery: Muirdale Sanatorium, Milwaukee. Tuberculosis: Muirdale Sanatorium, Milwaukee; Wisconsin State Sanatorium, Statesan. Urology: State of Wisconsin General Hospital, Madison; Milwaukee County Hospital, Milwaukee.

X-Ray Technicians

Madison General Hospital, Madison; Columbia Hospital, Evangel-

(Continued on page 5, column 2)

NEW CALIFORNIA LAW—

(Continued from page 1)

year, the total amount may not exceed one and one-half times the amount formerly payable under the act, and the employee is ineligible for disability benefits in any week during which he has received, or is entitled to receive, unemployment compensation benefits.

Voluntary Plans Acceptable

Application may be made for approval of a voluntary plan for the payment of disability benefits by an employer, a majority of the employees, or both. Neither an employee covered by an approved voluntary plan, nor his employer, is liable for the contributions required by this act, and such an employee is not entitled to benefits from the Disability Fund while he is covered by the voluntary plan. An employer may, but need not, assume all or part of the cost of the plan; deductions may be made from wages for such plans, but not in amounts exceeding those set out in the act. To be approved, voluntary plans must satisfy these conditions:

(1) The rights afforded to the covered employees are greater than those provided for in this act.

(2) The plan has been made available to all of the employees of the employer employed in this state.

(3) A majority of the employees have consented to the plan.

(4) Any insurance policies provided for must be approved by the Insurance Commissioner.

(5) The employer has consented to the plan and agreed to make any pay roll deductions required.

(6) Future employees must be included.

(7) Plan is to be in effect for at least two years, and thereafter until a majority of the employees give notice of its termination.

(8) The approval of the plan must not result in a substantial selection of risks adverse to the Disability Fund.

ANNUAL MEETING *News*

105th ANNUAL MEETING
MILWAUKEE, OCTOBER 7-8-9
STATE MEDICAL SOCIETY of Wisconsin

Milwaukee, Oct. 7–8–9

News on General Program: Monday morning features include scientific papers on the following subjects: "The Management of Dermatosis in General Practice," Stephan Epstein, M. D., Marshfield; "Diagnosis of Obscure Fevers in General Practice," Samuel Rosenthal, M. D., Milwaukee; "Management of Respiratory Emergencies," Ralph M. Waters, M. D., Madison; "Infectious Hepatitis," M. Herbert Barker, M. D., Chicago; and "The Treatment of Malaria," Maurice Hardgrove, M. D., Milwaukee.

Demonstrations New Feature: Each day, in connection with the Round-Table Luncheons, in addition to an obstetric manikin demonstration, one clinical demonstration will be presented, with patients serving as demonstration subjects. On Monday the clinical demonstration will be presented by Drs. Theodore Erickson and L. W. Paul, Madison, on the subject: "Disc Syndrome and Its Diagnosis." Tuesday noon the clinical demonstration will be on the subject of "Cardiac Diagnosis" by Dr. Chester M. Kurtz, Madison, while Wednesday's demonstration, presented by Dr. T. L. Squier, Milwaukee, will be on the subject: "Demonstration of Diagnosis and Treatment of Allergic Diseases."

W. J. Bleckwenn

Colonel Bleckwenn Gives Special Lecture: The Theresa Limberg Rogers Memorial Lecture, provided through the Rogers Memorial of Oconomowoc, will be given by Colonel Bleckwenn of Madison who rendered distinguished service as a neuropsychiatrist in the South Pacific during the early years of the war, and has recently returned to the Medical School at the University of Wisconsin. With his wide experience in the area of military psychiatry, Colonel Bleckwenn's scientific paper gives promise of being one of the highlights of the scientific assembly in October.

Rural Health Education Committee Created at Statewide Conference

Doctor Neupert Named Chairman

Madison, Mar. 19—At a statewide conference of representatives of farm organizations, state and federal agricultural agencies, doctors, dentists, public health nurses, University of Wisconsin, and the State Board of Health, Wisconsin's first Rural Health Education Committee was created here today.

Committee Members Announced

Dr. Carl N. Neupert, state health officer, was selected as chairman and subsequently announced the following committee members: Mrs. Evelyn Witt, educational director, Wisconsin Farmers Union, Chippewa Falls; William Kasa Kaitas, director of information, Farm Bureau Federation, Madison; Edith Bangham, assistant state leader of home economics, University of Wisconsin Extension Division, Madison; and Charles H. Crownhart, Secretary, State Medical Society, Madison.

First task of the committee will be to assemble existing information on rural health services being performed by the various agencies in the field, and to make it available to interested organizations. The round-table discussion at the conference brought out the fact that rural public health could be better served if all the different organizations in the field knew the health goals and carried out a well-formulated plan.

C. N. Neupert

APPROVED HOSPITALS—

(Continued from page 4)

ical Deaconess Hospital, Mount Sinai Hospital, St. Joseph's Hospital, Milwaukee.

Clinical Laboratory Technicians

St. Francis Hospital, La Crosse; Madison General Hospital, St. Mary's Hospital, State of Wisconsin General Hospital, Madison; Milwaukee County Hospital, Milwaukee Hospital, Mount Sinai Hospital, St. Joseph's Hospital, Milwaukee.

CAP VIEWS—

(Continued from page 3)

it's a story with a point. It is hoped that it will produce reaction.

Not many years ago a prominent Wisconsinite and his son were traveling one of this state's unpaved highways on a dark and rainy night. Suddenly, in the midst of nowhere, they saw a red lantern flagging them to a stop. They stopped, thinking, rather naturally, that the road was impassable ahead. A gaunt figure of a man came to the car window and asked, "How are the roads?" "O. K. to here," was the reply. "In fact, they are fine. What's the trouble?" "No trouble," the man answered, "but I'm the highway maintenance man and the only way I can find out what people think of the roads is to stop them and ask."

Loan Packets

The Office of the State Medical Society has available loan packets for lay or professional use on the subject of the Wagner–Murray–Dingell Bill and related matters.

HOSPITAL SURVEY—

(Continued from page 2)

form the major parts of a coordinated state-wide hospital system?

(6) How many doctors, specialists, nurses, dentists, technicians, and other hospital employees will be needed to enable hospitals to render maximum service?

(7) How much of the hospital service will the patients be able to pay for and how much must be paid by other sources?

(8) In the light of social and economic trends in the state, how much expansion in hospitals will likely be needed for the future?

Nationwide Progress Reported

"Thirty-one states have surveys under way, and others are interested in getting a survey started," according to Dr. D. B. Wilson, Assistant Director of the Commission on Hospital Care, speaking before the 15th Mid-Year Conference of Presidents and Secretaries of state hospital organizations, held in Chicago February 7 and 8. "In twenty-one states," Doctor Wilson declared, "the surveys are being conducted by the state health department (as in Wisconsin), in eight states by governors' commissions, and in two states by post-war planning commissions. All have advisory councils representing health and other interests. Ten states had legislation passed authorizing surveys. The other twenty-one now conducting surveys are doing so by official direction, most often by the governor. There is no set pattern for financing the surveys. In some states there are special appropriations; others use funds from agencies already in existence."

With the publicity which the survey and the pending legislation (Hill–Burton Bill S-191, concerning hospital surveys and construction programs), several communities have already inquired as to the possibility of obtaining federal aid for local hospital projects. In fact at least twenty-one communities are contemplating the construction of additional or new facilities, with goals set that total approximately $6,000,000, it has been learned through a newspaper clipping service. Under the proposed federal legislation Wisconsin would receive $1,648,000 each year for five years, to be allotted to approved projects as federal grants-in-aid up to 52 per cent of construction costs, according to the formula laid down by the Office of the Surgeon General. To receive this sum, $1,521,000 of state, local, and private funds would have to be provided each year. The federal grants-in-aid would be made available for projects approved by the Board of Health and the Surgeon General based on a priority for greatest need and in accordance with general regulations issued by the Surgeon-General's Office of the United States Public Health Service. Funds would also be made available for defraying costs of making the hospital survey, each state to receive 50 per cent of its expenditures, within limits, and in no case less than $10,000.

Bill S-191, the "Hospital Survey and Construction Act," passed by the Senate December 11 and now before the House, is set up to assist the several states to:

(1) inventory their existing hospitals, to survey the need for construction of hospitals, and to develop programs for construction of such public and other non-profit hospitals as will, in conjunction with existing facilities, afford the necessary physical facilities for furnishing adequate hospital, clinic, and similar services to all their people, and

(2) construct public and other non-profit hospitals in accordance with such programs.

Compensation Granted Student Nurse Who Contracted TB in Employment

Ruling Being Watched With Interest By Wisconsin Hospitals

A recent ruling of the Wisconsin Industrial Commission, granting compensation to a Wisconsin student nurse employed in a Madison hospital, on the basis that her illness was contracted as a result of her employment, is being studied by many Wisconsin hospitals, which view the case as a test regarding their liability to nurses in training and other employees.

(The ruling of the Industrial Commission is likewise viewed with interest by the medical profession in light of a current recommendation by the State Medical Society's Committee on Tuberculosis and Chest Diseases that hospitals engaged in training of nurses carry out a well-defined program of chest examinations during frequent intervals while students are in training, and for a specified period after graduation.

The same committee has likewise given considerable study this past year to the program being conducted through several hospitals, with the use of equipment furnished through the State Board of Health to check all hospital admissions through routine x-rays.)

In presenting its ruling the Industrial Commission noted that the illness was contracted during the term of employment and stated:

"That student nurses who render service in hospitals in exchange for instruction, maintenance, etc., are employees and entitled to the benfits of the Workmen's Compensation Act is established by *Employers Mutual Liability Insurance Company vs. Industrial Commission and Deluhery*, 235 Wis. 270, and is conceded by the Attorney General to be the general rule."

The ruling, awarding financial indemnity to the complainant and attorney fees to those representing her, has been appealed and will be carried to a court of higher jurisdiction for review.

RIPON CHIROPRACTOR HELD ON TWO CHARGES

Ripon, Wis., Mar. 22—After a preliminary hearing in Municipal Court, a local chiropractor, George C. Yeomans, was bound over for trial at the May term of the Circuit Court for Fond du Lac County on two charges.

"The first charge involved the unauthorized use of the title 'Dr.,'" reports Kenneth S. White, attorney for the State Board of Medical Examiners, "and the evidence offered by the District Attorney showed that the defendant had furnished copy for a paid advertisement in the Berlin Journal in which the title 'Dr.' appeared before his name."

The second charge involved the practice of medicine without a license. The defendant had prescribed and sold to a patient two bottles containing products prepared by the Vitaminerals Company of Los Angeles, California. Evidence offered by the District Attorney indicated that one of the products was a laxative and the other an iron mineral tonic.

The defendant offered no evidence at the preliminary hearing.

EXPANDED APHA MEDICAL CARE PROGRAM MADE POSSIBLE BY ROCKEFELLER GRANT

Technical Secretary Named For Subcommittee on Medical Care

The expansion of its activities in support of a general medical care program is announced by the American Public Health Association. Stating that the Rockefeller Foundation has made a financial grant for this purpose, the Association declares that it has appointed a Technical Secretary for its Subcommittee on Medical Care, and that an assisting staff is now being selected.

Howard M. Kline, Ph. D., Technical Secretary, and his staff will carry out the program which the association asserts can be realized in ten years. Its four major aims are:

(1) To formulate in considerable detail the specifications of a suitable medical care program, and to set forth with definitiveness the succesive steps by which such a program should be brought into being, and further to formulate detailed proposals for the organization, financing, and administration of a program.

(2) To evaluate, concurrent with the above, the experience of existing medical care programs, thus laying the basis of factual knowledge necessary for solution of the problem.

(3) To review proposed federal and state health legislation in the light of declared principles and to recommend to the Association a stand with respect to such legislation.

(4) To aid in informing public health personnel as to medical care problems and to stimulate the assumption of leadership in the formulation and administration of medical care programs.

See The Medical Forum, February, 1945, for complete details of the national compulsory health program proposed by the American Public Health Association.

The enlarged membership of the subcommittee includes: Joseph W. Mountin, M. D., Chairman, U. S. Public Health Service; Dean A. Clark, M. D., Medical Director, Health Insurance Plan of Greater New York; Edwin F. Daily, M. D., U. S. Children's Bureau; Isidore S. Falk, Ph. D., Director, Bureau of Research and Statistics, Social Security Board; Vlado A. Getting, M. D., Massachusetts State Commissioner of Public Health; J. Roy Hege, M. D., North Carolina State Board of Health; Basil Mac Lean, M. D., Superintendent, Strong Memorial Hospital, Rochester, New York; Hugh Morgan, M. D., Vanderbilt University School of Medicine; George St. John Perrott, U. S. Public Health Service; Marian G. Randall, R. N., Executive Director, Visiting Nurse Service of New York; Dean Roberts, M. D., Maryland State Health Department; Edward S. Rogers, M. D., New York State Department of Health; Nathan Sinai, Dr. P. H., University of Michigan; R. M. Walls, D. D. S., Bethlehem, Pennsylvania; John B. Grant, M. D. and Hugh R. Leavell, M. D., Consultants, Rockefeller Foundation.

RALPH WEBER JOINS STATE MEDICAL SOCIETY STAFF

Mr. Ralph F. Weber of Milwaukee joined the staff of the State Medical Society March 18 as an executive assistant to aid in developing the Society's health insurance programs, including "The Wisconsin Plan," the Farm Security program in Price and Taylor Counties, and other related projects.

For the last two years Mr. Weber has been the business manager of the Milwaukee County Chapter of the American Red Cross. For the ten years prior to that he served as assistant executive secretary of the Medical Society of Milwaukee County. During that time the experimental plan for a joint state-county program of health insurance was developed at the village of Greendale.

Mr. Weber plans to move his wife and two children to Madison when conditions permit.

KETCHUM NAMED—

(Continued from page 2)

vices will be provided or cash indemnities paid. All exclusions, waiting periods, and deductible provisions must be clearly indicated in the promotional literature and in the contracts.

Promotion: (10) Promotional activities must be reasonable without extravagant or misleading statements concerning the benefits to the subscribers. In approving promotional material the Council will endeavor to indicate the type of statements which are acceptable and the nature of those considered objectionable. It is not the function of the Council to edit all copy word for word and sentence for sentence, but rather to indicate the general type of revision required in any given piece of literature. It expects the spirit and intent of such objections to be observed in the remainder of the copy not specifically criticized. Promotional activities will include any devices for informing the public or the profession.

Enrollment: (11) Enrollment practices shall be based on sound actuarial principles such as will not expose the plan to adverse selection. Group enrollment is recommended until further experience warrants the acceptance of individuals.

(12) It is understood that the plan of organization will conform with state statutes and that the plan will operate on an insurance accounting basis with due consideration for earned and unearned premiums, administrative costs and reserves for contingencies and unanticipated losses. Supervision should be under the appropriate state authority.

(13) Each accepted plan must submit periodic reports of financial and enrollment experience in the manner prescribed by the Council.

Duration of Acceptance: Acceptance of plans by the Council will be for a period of two years or until revoked (provided they comply with the standards during this period) at the end of which all contracts and financial statements be re-examined. A shorter period of approval may be granted at the discretion of the Council. Any changes in contracts or literature during the period of acceptance must be submitted to the Council for review.

N. Y. PLAN SHELVED—

(Continued from page 1)

After fifteen months' study, the Commission decided that further study was indicated as necessary before experimenting in a heretofore non-governmental field, with a plan demanding such great expenditures and affecting thirteen million people.

Recognizing the many factors bearing on the subject of health, the Commission did recommend the following: (1) extension of public health and welfare services, (2) state aid for hospital construction, (3) development and extension of diagnostic aid facilities, and (4) state support for specific medical research projects.

Child Care Program Urged in Minority Report

A comprehensive medical, dental, hospital, and nursing care program for children under eight years of age, to develop a pattern for the evolution of programs with fuller coverage, was recommended in the first of four minority reports simultaneously presented to the Legislature. The report, signed by five members of the Commission, recommended that the program be closely integrated with but not duplicating those systems of health education, communicable disease prevention, and child guidance presently entrusted to departments of public health, education, and mental hygiene.

Physicians, dentists, nurses, and institutions would not be in the employ of the state according to this plan, which would be administered by an official state agency, with local advisory councils, the executive being a physician experienced in administration.

A hospital licensure law was recommended for adoption, in conjunction with the above medical care plan, to "aid in improving the medical care received by the people of New York State through the development and enforcement of good standards of care in the many institutions not now under supervision."

The provision of hospital care for tuberculosis and mental disease at public expense was finally recommended, as benefiting the community by requiring those needing medical treatment to be hospitalized, thus aiding in disease control.

Medical Care Through Payroll Taxes

Complete medical care financed by a payroll tax was proposed in a lengthy report prepared by Assemblyman Leonard Farbstein, who charged the signers of the majority report with having "yielded to the presence of the special interests" and having failed in their mission, and who introduced into the Legislature on January 14 an Act "to amend the public health law, in relation to providing for the organization and operation of a comprehensive statewide system of health insurance." According to its author, "the main features of my comprehensive health plan are identical with those of the Wagner–Murray–Dingell bill and my plan would fit easily into the National Health Plan."

Need for Further Study Reported

"Failure to propose a health insurance plan for the people of the state does not mean that the work of the Commission has been without profit," says Dr. Robert L. Levy in the third minority report. "It has served to indicate," he continues, "that the time for definite action, on a large scale, has not yet arrived. Any experiment involving one-tenth of the population of the United States and costing half a billion dollars per annum, should be undertaken only when careful planning, based on sound premises, affords reasonable assurance of success."

Urging the Legislature to "find some device by which it may further pursue the project on which the Commission on Medical Care has been engaged," Robert T. Lansdale, State Commissioner of Social Welfare, submitted the fourth minority report. "My chief disagreement with the report of the majority of the Commission on Medical Care," he states, "is that the statement does not re-affirm a belief that social insurance represents the most practical means in sight for financing medical and hospital care for large numbers in the lower income groups."

Pointing out that the solution to the public medical and hospital care problem is primarily an economic one, he urges that the best brains in public finance, actuarial science, and public administration be devoted to the problem.

The
MEDICAL FORUM

The Wisconsin Medical Journal May, 1946

"WISCONSIN PLAN" SETS THE PATTERN

Veteran MDs May Receive Pay For On-the-Job Training

Advisory Committee Recommendations Cover Many Related Fields

Extension of G. I. benefits to physicians taking refresher courses or working under an approved preceptor was recommended by the Advisory Committee on Postwar Medical Services, meeting in Madison on April 23.

The committee, serving under the chairmanship of Dr. Walter J. Meek, specifically recommended that training leading to specialty board recognition may be carried out either in an institution approved by the Council on Medical Education and Hospitals of the American Medical Association or through on-the-job training approved by the appropriate specialty board.

G. I. benefits would also be available to veterans enrolled in short intensive postgraduate refresher courses offered by institutions approved by the Council on Medical Education and Hospitals of the A. M. A. or through on-the-job training under an approved preceptor for a period of not less than three months.

To date the state advisory committee has not set standards for approved preceptors, but if the basic recommendations of the committee are accepted by the Governor's Veterans Education Advisory Committee, the state Advisory Committee on Postwar Medical Services will work out further details which will be reported to all physician veterans who might wish to avail themselves of the financial assistance offered through refresher courses or through on-the-job training.

It is anticipated that the Governor's Veterans Advisory Committee, if it approves the recommen-

(Continued on page 6, column 3)

TOM DORAN TO DIRECT PEDIATRIC SURVEY

Madison, April 27—Thomas J. Doran, City Relief Director, has been named executive secretary of the survey of child health facilities to be conducted by the American Academy of Pediatrics under the

State Journal Photo
THOMAS J. DORAN

state chairmanship of Dr. H. Kent Tenney, Madison pediatrician. Mr. Doran, who has been granted a six months' leave of absence to direct the survey, entered welfare work fourteen years ago as a caseworker in Rock County, after attending Marquette University and the General Motors Institute of Technology. He served as Director of Relief in La Fayette County for four years, before being named Director of the Madison Relief Department eight years ago.

Commenting on the concern among physicians caused by the tendency of government agencies to expand their activities and encroach on the field of medical practice, Doctor Tenney stated that "at the November, 1944, meeting of the Academy it was decided that the

(Continued on page 5, column 2)

California and Illinois Follow Wisconsin's Lead in Insurance Plans

Following a pattern similar to that set by the State Medical Society of Wisconsin in developing the "Wisconsin Plan" of voluntary prepayment medical care insurance, the Illinois State Medical Society has an agreement with several commercial carriers to model a plan in that state.

It has also been announced that California is considering a proposal following the same pattern as the "Wisconsin Plan," five insurance companies having joined together to form the California Health Insurance Conference and to launch a low cost accident and health insurance program, to be known as the "California Plan." The five companies (Associated Indemnity, California-Western States Life, Federal Life, Occidental Life of California, and Pacific Employers) banded together to underwrite low cost, comprehensive medical and hospital insurance for California residents, after consultation with the California State Medical Association.

Payment will be guaranteed for expenses incurred for medical, surgical, and hospital care under uniform indemnity schedules in policies which may be written either on individual persons and families or on groups of 10 or more persons such as employees of a common employer, members of labor unions, employee or trade associations, and farm granges.

The standard medical service fees under the proposal would be applicable to those whose annual earnings are under $3,000 if single, $4,000 if married but without a family, and $5,000 if married and parents of children under 18. Physicians and surgeons would automatically charge standard fees provided in the insurance policies to their insured patients in income levels below the agreed amounts.

(Continued on page 2, column 1)

Federal Funds Spent For Health in Wisconsin

WISCONSIN PLAN LEADS

(Continued from page 1)

Benefit payments to insured persons of higher income would be made on the standard schedules but doctors would reserve the right to charge them larger fees against which the benefits would serve as partial payment. It is estimated the plan would cover 95% of the medical care and hospitalization costs needed by persons in the lower income brackets.

Stating that the California Medical Association is trying to "accomplish in the next two years what has been achieved in the field of life insurance during its 100-year period of existence," and that the medical profession realizes it cannot do the job alone, Dr. John W. Cline, vice-chairman of the Association, called for the "help and active cooperation of business and civic organizations, press, and leaders in every walk of life," to assure the success of the plan.

Viewed generally as the first move on the part of the accident and health industry to meet the threats implied in California's newly passed disability insurance law, the plan is believed to provide all the benefits claimed for socialized medicine with none of the disadvantages to patient or doctor. Specific advantages claimed for it by executives of participating companies are: The plan is voluntary. None but those who want the benefits need take it. The participant remains free to choose his own physician, surgeon, or hospital, and to change his selection at will. Where the insured is a member of a group of covered persons, indemnification will be made for disabilities existing when the coverage goes into effect, according to present plans.

Avoiding the need for new governmental agencies or bureaus to administer the plan, benefits will be provided by an extension of the existing organization of the underwriting companies, using their trained personnel which is already administering similar but less extensive plans now in force on employees of hundreds of business firms and county, state, and city personnel groups.

(Continued on page 7, column 3)

More than $1,250,000 of the federal funds expended for health purposes in Wisconsin are administered by various divisions of the State Board of Health, though smaller sums are spent through the Rehabilitation Division of the State Board of Vocational and Adult Education, the Bureau of Handicapped Children of the Department of Public Instruction, and the Division of Public Assistance of the State Department of Public Welfare.

Approximately $556,000 of federal monies is administered by the State Board of Health, independent of the EMIC program, a wartime measure. A total of $460,233 from the U. S. Public Health Service, matched by state appropriations, is expended as follows: (1) General Health, $216,537; (2) Venereal Disease, $117,055; and (3) Tuberculosis, $126,641. The money expended for "general health" covers such costs as statistics, sanitation, State Laboratory of Hygiene, general health education, district health programs, industrial hygiene, etc.

The $96,396 from the Children's Bureau is divided into two funds: one amounting to $79,643 consists of money matched by state funds to cover salaries, expenses of such persons as director of mental health and consultant in pediatrics, printing health education pamphlets, conduct of mental health clinics, etc; the second fund of $16,753 is made up of federal funds not matched by the state, and is designed to cover projects where economic need is demonstrated and for which state funds are not available.

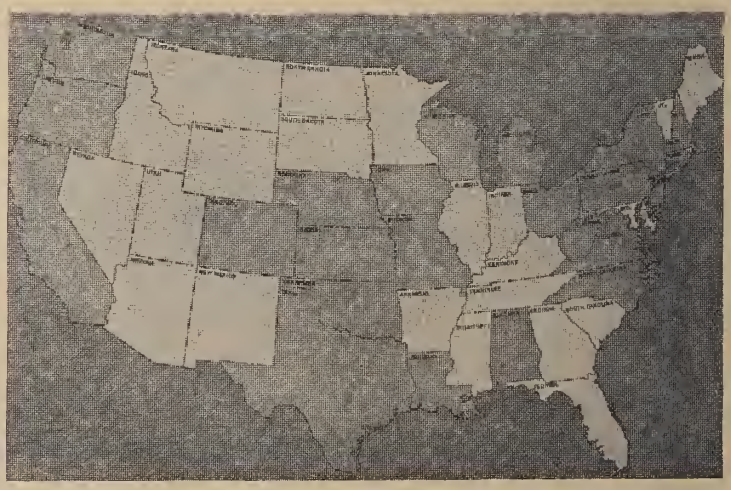
Funds made available to the Board of Health through the EMIC totalled $754,861 (for the fiscal year ending June 30, 1946). These funds, of a wartime nature, will terminate about eighteen months after the war is declared over. This brings the total funds from federal sources for the Board of Health for one year to $1,311,490.

An estimate of $32,000 spent for medical examinations and medical care in the year was made by the Rehabilitation Division of the State Board of Vocational and Adult Education. Of this amount $16,000 was allotted from state funds and an equal amount from federal funds.

Of the $82,000 total expended by the Bureau of Handicapped Children of the Department of Public Instruction, $62,000 was used for crippled children and $20,000 for the rheumatic fever program.

(Continued on page 8, column 3)

STATES WITH MEDICAL SOCIETY SPONSORED PRE-PAYMENT PLANS



THE 25 STATES SHADED HAD OVER 60 PLANS, AS OF MARCH 1, 1946.

(Reprinted with permission of "Medical Economics," Inc.)

Washington observers believe that Wisconsin is building towards a number one man in the national capitol. Julius Krug, successor to Ickes as Secretary of the Interior, is gaining increased attention as an active and energetic administrator.

* * *

But coming closer to home, it was suggested in this column a year ago that the cost of medical care under government systems does not follow the experience that is statistically reported for the country as a whole. For example, the Social Security Board recently reported that the total bill for civilian health including hospital construction has been, in ordinary years, about $30 per person, with about one-fifth borne by public funds.

However it has been reported here that in the care of government-imported workers from Jamaica, the Bahama Islands, and Mexico, the cost was running about $18 to $24 a year. And it is important to keep in mind that these workers are carefully screened before being accepted. This would indicate that under a governmental system, per capita costs would increase markedly.

Now various individuals are saying that if the government could devise an effective "direct service" program, this cost would be substantially lowered. At present, because of lack of concentration of these workers, the referral (to a physician of choice) system is used.

* * *

One of the disappointments to those who are directing the activities of the State Board of Vocational and Adult Rehabilitation services has been the lack of funds available to fully implement the Barden–La Follette act. Under this law, federal funds are available on a matching basis with state appropriations. Proposals now involve earmarking a substantial amount of the next budget for medical attention exclusive of the required physical examination.

THE WISCONSIN PLAN PROGRESSES

With participation of physicians in the "Wisconsin Plan" in 69 counties, the State Medical Society announces 100% enrollment of its members in 43 counties, majority participation in 20 counties with the 100% expected shortly, and approximately 50% enrollment in 6 counties.

The printed panel listing participating physicians should be prepared before the end of May for distribution to subscribers.

Twenty-five insurance companies, both stock and mutual, are selling the "Wisconsin Plan" and are as follows: Aetna Life, Hartford, Connecticut; American Motorists, Benefit Association of Railway Employees, Lumbermen's Mutual Casualty, Washington National, and Continental Casualty, Chicago; American Mutual, and Liberty Mutual, Boston; Business Men's Assurance, Kansas City; Celina Mutual Casualty, Celina, Ohio; Employers Mutuals, Wausau; Federal Casualty, Great Northern Life, Old Line Life, Personal Indemnity, and Time Insurance, Milwaukee; Hardware Mutual, Stevens Point; Illinois Mutual Casualty, Peoria; Lincoln National Life, Fort Wayne; Mutual Indemnity, Madison; North American Life and Casualty, North American Accident, Minneapolis; Provident Life and Accident, Chattanooga, Tennessee; Wisconsin National Life, Oshkosh; Woodmen Accident, Lincoln, Nebraska.

Others, having indicated an interest, will be included in this list as they sign the "Statement of Principles."

Probably by the time this appears in print Senator Taft of Ohio will have introduced a proposal for a national health program. It is rumored that much of the preparatory work on this proposal came from an individual who formerly worked in official Washington health agencies, but whose concept of governmental medicine does not follow the lines established by officialdom.

* * *

While the Secretary of Labor, Lewis B. Schwellenbach, is urging Congress to broaden the Social Security law to include some 20 million unprotected persons, and to provide sharp increases in the old age benefits, those in charge of the government funds are concerned with the financing of present benefits. The trustees report that payments currently total about $250 million a year, but are expected to increase some 15 to 25 times during the next several decades. They prophesy that a direct governmental subsidy from general revenues will be required to meet the benefits of the system unless the contribution rate is increased. And while this is being considered, Secretary Schwellenbach argues that the benefit rate should be increased since it is estimated that living costs have increased 33 per cent since 1941. Many persons argue that this situation speaks for itself when an analogy is drawn as to what might happen if a similar device were used to pay costs of medical care.

YOU WRITE THE CHECK

Yes, Doctor, when you complete a claim report for your patient you are in almost every case specifying the amount of that person's claim check.

TIME has paid millions of dollars to Wisconsin people on merely the Doctor's statement. Our faith in the Doctor is justified.

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Procurement and Assignment Service to End May 15

Milwaukee, Apr. 24—Having provided 1,175 Wisconsin doctors for military service, the Wisconsin Office of Procurement and Assignment of physicians for the armed forces will close May 15, Dr. Robert E. Fitzgerald, state director, announced today.

R. E. FITZGERALD

Approximately twenty-five more doctors will be assigned within the next few weeks, to replace doctors who served during the war. These men are residents and interns who have been on reserve status while getting experience in civilian hospitals.

While many Wisconsin doctors volunteered for military service, all others among the 3,391 in the state were surveyed by the office, which suggested to those who could be spared that they volunteer. Making a draft of doctors unnecessary, this system also kept a sufficient number at home to meet community needs.

Hospitals were rationed on resident physicians and interns and training courses were shortened. Under current regulations, each hospital will be free of restrictions when all interns and residents subject to military service join the armed forces or are rejected. The hospital may then resume a standard program.

Hospitals which do not have enough interns are taking war veterans as residents. Some hospitals are retaining doctors due to be called until they can be replaced. By July 1, however, said Doctor Fitzgerald, all men subject to military call will be taken.

RHODE ISLAND MEDICAL SOCIETY SPONSORS SURGICAL INSURANCE PLAN

A prepaid voluntary surgical insurance program is to be offered by the Hospital Service Corporation (Blue Cross) in cooperation with the Rhode Island Medical Society. This plan is the result of a year of study by a committee of physicians and laymen and will operate under a single corporation (Blue Cross), with one board of directors and one executive director for both the hospitalization and surgical services.

One of every four members of the board of directors will be a physician elected by the Rhode Island Medical Society. All income from the sale of the insurance will be maintained in a separate fund, participating physicians being paid from it in accordance with a fee table established by the society and subject to amendment only by it. Participating physicians will contract with the Hospital Service Corporation to be eligible, and must agree to accept a proration of fees, if necessary, to maintain the solvency of the surgical fund.

To guarantee a permanent medical representation on the board of directors the Blue Cross adopted amendments to its by-laws. A fee table for the surgical procedures to be covered has been drafted by the society's house of delegates, meeting in special session.

This plan is one of sixty-two now in existence in the country which feature voluntary prepayment medical care and are approved by state and county medical societies.

CONVICTION FOR USE OF TITLE "DOCTOR"

Pleading guilty to the unauthorized use of the title "Doctor," George C. Yeomans, Ripon chiropractor was fined $200 and costs at the May term of the Fond du Lac County Court.

According to information received from Kenneth White, attorney for the State Board of Medical Examiners, a second count, involving the practice of medicine without a license, was dismissed.

The defendant had a preliminary hearing in Municipal Court in March, and was bound over for trial in the Circuit Court on the two charges.

FIVE MEDICAL OFFICERS NAMED TO VOCATIONAL REHABILITATION

Washington—To aid in the expansion of its physical restoration program, the services of five new medical officers have been acquired by the Office of Vocational Rehabilitation of the Federal Security Agency, according to an announcement by Director Michael J. Shortley, who also indicated that additional full-time posts in the fields of ophthalmology, hospital administration, tuberculosis, and psychiatric social work are proposed.

Pointing out that the OVR has just completed its first full year of operation under Congressional amendments which permit it to offer comprehensive medical, surgical, and psychiatric services to disabled persons, Shortley said that appointments of additional qualified medical personnel would make possible the fullest utilization of the Federal–State rehabilitation program.

"We anticipate that additional positions soon will be established for full-time consultant positions in ophthalmology and hospital administration in the Washington office," Shortley said. The medical officers of the staff act principally in the capacity of consultants to state vocational rehabilitation agencies which, in turn, purchase necessary services from local physicians and hospitals.

Among those named to the medical post is Dr. C. L. Newberry of Milwaukee who was graduated from Marquette Medical School in 1926, engaged in private practice in Milwaukee, and was associated with the city health department. On December 7, 1941, he transferred to the Farm Security Administration as senior medical officer and was later commissioned in the United States Public Health Service and reassigned to the Farm Security Administration. In January, 1945, Doctor Newberry joined the UNRRA as director of health in the Middle East Mission at Cairo, Egypt, leaving this post in June of the same year to go to London to help organize the health staff for the then-forming Austrian mission. He departed from London last August, and went first

(Continued on page 7, column 2)

ANNUAL MEETING *News*

105th ANNUAL MEETING
MILWAUKEE, OCTOBER 7-8-9
STATE MEDICAL SOCIETY of Wisconsin

Milwaukee, Oct. 7–8–9

■ **RH FACTOR:** The first portion of the Monday afternoon scientific session (October 7) will be devoted to the Rh Factor. William Stovall, Madison, will start the discussion with a paper on *The General Conception of Rh Factor in the Blood,* to be followed by papers on *The Rh Factor in Obstetrics,* by Jack Klieger, Milwaukee, and *The Rh Factor in General Practice,* by G. P. Langenfeld, Theresa.

* * *

■ **NESSELROD AND CURTIS TO SPEAK:** The Monday afternoon scientific session will conclude with papers presented by J. P. Nesselrod, Northwestern Medical school, who will discuss *The Diagnosis and Treatment of Common Rectal Complaints;* and George M. Curtis, Columbus, Ohio, who will present a paper on *The Use of Thiouracil and Lugol's Solution in the Preoperative Preparation of the Thyrotoxic Patient.*

G. P. LANGENFELD

■ **NEW RADIOLOGY PROGRAM PLANNED:** In previous years the section on Radiology has presented a program composed of case studies, of special concern to radiologic specialists. At the request of the Council on Scientific Work, L. V. Littig, chairman for 1946, has prepared a program designed to interest the general practitioner as well as the radiologist. The diagnostic essayists will show and discuss normal findings and frequent pathology of general interest encountered in x-ray practice.

The program, approved by the Council on Scientific Work, is as follows:

Chest and Heart: Russell F. Wilson, Beloit

Gall Bladder, Stomach, and Colon: C. F. Sherman, Madison

Kidneys, Preliminary Examination and Urography: Ralph L. Troup, Green Bay

Fundamental Principles of Radiation Therapy: E. A. Pohle and Elizabeth A. Clark, Madison

Bone and Joint Conditions Other Than Fractures: Sam Morton, Milwaukee

Fractures, Wrist and Ankle: L. V. Littig, Madison.

TOM DORAN NAMED—

(Continued from page 1)

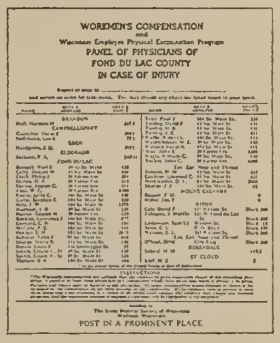
only logical approach to the whole problem was to make a state-by-state study of all child health facilities; from this to deduce each state's needs; and from this to determine what governmental participation in state programs was desirable."

Cooperating in Wisconsin in this state-by-state fact-finding study, conducted with the full approval and aid of the United States Public Health Service and the Children's Bureau of the United States Department of Labor, will be the State Board of Health, the Bureau for Handicapped Children of the State Department of Public Instruction, the state division of the National Foundation for Infantile Paralysis, and the State Medical Society of Wisconsin. It will follow four main fields of inquiry, including detailed information concerning: (1) hospitals, (2) community health services, (3) the extent of professional personnel, and (4) pediatric education.

A pilot study in the state of North Carolina, launched in September, 1945, and now successfully completed, has aided in the development of a successful pattern which can guide other state programs.

Participation in Panel Program Urged By Chairman Kurten

Racine, May 1—All members of the State Medical Society interested in participating in the Workmen's Compensation Program through panel listing for 1946–47 are urged to file their application blanks with the secretary's office in Madison on or before June 1.



WORKMEN'S COMPENSATION
and
Wisconsin Employers Physical Examination Program
PANEL OF PHYSICIANS OF
FOND DU LAC COUNTY
IN CASE OF INJURY

POST IN A PROMINENT PLACE

Dr. R. M. Kurten, chairman of the Conference Committee on Open Panels, in urging wide participation in the Open Panel Agreement emphasized the growing use of the unrestricted panel in Wisconsin as one more way in which the relationship of patient and his family physician can be retained.

"More than seventy-five per cent of our members are actively participating in this program," said Doctor Kurten, "and we feel sure that during these important postwar years the Open Panel program of the State Society will assume increased importance. The Wisconsin Industrial Commission and the many insurance companies which participate in the Open Panel Agreement with the physicians of Wisconsin are convinced that wide choice of medical care, such as offered in the county-wide panel program, has improved the quality of medical care and the standards of reporting."

All members of the State Society have been mailed application blanks and complete returns are requested prior to June 1. Commenting on the necessity for complete record-keeping, Doctor Kurten said that "all members, even though they do not wish to participate in the program because of their specialty practice, are requested to file their application forms with appropriate notices of their desire not to participate."

Infantile Paralysis Preparedness Conference Scheduled For June

Madison, Apr. 27—As the first step in a campaign to help prepare Wisconsin communities for possible poliomyelitis outbreaks this summer, the National Foundation for Infantile Paralysis and the State Board of Health are again co-sponsoring this year a two-day state preparedness conference to be held at the Hotel Pfister, Milwaukee, Tuesday and Wednesday, June 4 and 5.

Tuesday, the first day of the conference, sponsored by the State Board of Health, will be presided over by Doctor Carl N. Neupert, State Health Officer and the discussion will be on a professional level with Doctor Hart E. Van Riper, former Madison physician now acting medical director of the National Foundation for Infantile Paralysis, scheduled as one of the out-of-state speakers.

Doctor Van Riper was medical director at the Jackson Memorial Hospital at Miami, Florida when he affiliated with the National Foundation. During the 1944 outbreak of polio, he won national attention by skillful treatment of 36 victims of the epidemic. Mrs. Van Riper, wife of the former Madison physician, is a previous infantile paralysis patient stricken with the disease in August, 1943. She has since recovered almost completely.

In attendance at the preparedness conference will be state, district, and local health officials, representatives from the State Bureau for Handicapped Children, State Board of Vocational and Adult Education (Rehabilitation Division), State Medical Society, Wisconsin Hospital Association, and members of the Medical Advisory Committees of the County Chapters of the National Foundation.

The first day's session this year will be devoted to discussions of: (1) overall problems met in epidemics, (2) existing hospital facilities for early diagnosis and treatment of polio patients, and (3) the number of physicians, nurses, and physical therapists available in the event of an epidemic.

The second day's session sponsored by the National Foundation will be presided over by Palmer F Daugs, its Field Representative in Wisconsin. In attendance will be representatives of the 72 County Chapters in Wisconsin (Washington County having a North and South County Chapter). State officials and Foundation representatives will discuss plans for coordinating the facilities, resources, and personnel of existing health agencies.

NEW ARMY MEDICAL LIBRARY SOUGHT

A new Army Medical Library building, to be located on Capitol Hill, long recognized as vitally essential for the rendering of effective service to the medical profession, is proposed in a bill to be presented before the Budget and Congressional Committees at forthcoming hearings.

The hearings which were in progress before the outbreak of war, at which time there was advocated a new Army Medical Library building to be erected at a cost not to exceed $4,750,000, having been terminated during the war were resumed in April.

Reorganization of the library, and an increase in its size to over a million items and a personnel of one hundred and fifty, have made it impossible to carry on in the present building, erected in 1887.

Increased costs, together with modernization and expansion of the original building plans, have raised to $10,000,000 the amount asked of Congress.

PALMER F. DAUGS

Advance Reservations For Clinics Heavy, Reports Coon

Madison, May 1—Advance reservations for the June Postgraduate Teaching Clinics, to be held in Wisconsin Rapids, Fond du Lac and Monroe, are unusually heavy according to Dr. Harold M. Coon, program chairman.

"With many members returning from service we expect a record-breaking attendance at all three of the clinics," said Doctor Coon. "The resumption of the full-day teaching clinics has met with enthusiastic response, and we are being faced with problems of accommodating those who have signified their intention to attend, and still retaining the intimate relationships which are of particular importance in the round-table dinner discussions.

"With one of our clinics located close to the Illinois border we have extended our invitation to physicians in Rockford, Freeport, and other north-central Illinois communities, as well as the physicians in Dubuque, Iowa.

"If you have not yet sent in your reservation you are urged to do so, as dining facilities in some instances are limited, and we cannot assign more than thirty physicians to any one discussion group for dinner meetings."

VETERAN MDs—

(Continued from page 1)

dations submitted covering physicians' participation in the on-the-job training program, will name the Advisory Committee on Postwar Medical Services as the official approving agency for all programs covering Wisconsin physicians.

In addition to recommendations covering physicians and their relation to G. I. Bill participation the Advisory Committee made separate recommendations for on-the-job training programs in occupational therapy, clinical laboratory technology, x-ray technology, physical therapy, nursing, and dentistry.

Members of the Advisory Committee, in addition to Walter J. Meek, are George Wilson, D. D. S.; Carl N. Neupert, M. D.; H. H. Christofferson, M. D.; Mr. Fred Bishop; Mrs. C. D. Partridge; and Mr. O. H. Plenzke.

Cancer Committee Announces Completion of New Slides For Education of Lay Groups

Madison, May 4—The Committee on Cancer, under the chairmanship of Warner S. Bump, Rhinelander, announces the completion of a series of 2" x 2" glass slides on the subject of cancer, primarily intended for lay audiences.

WARNER S. BUMP

In commenting upon the slides Doctor Bump said:

"The series of pictures has been purposely made simple. After indicating the seriousness of the cancer problem the slides present some elementary information on how cancer is a wild growth of cells, how it is transmitted to various sections of the body through the blood stream, and how early detection and treatment by recognized medical procedures can save many lives now lost.

"The slides have been compiled from numerous sources. Some are taken from the cancer film strip prepared by the State Society in other years; others are taken from a recent film strip of the Zurich Insurance Company, prepared in collaboration with the American Cancer Society; and several of the slides are based on statistics gathered from the State Board of Health.

"When you are called upon to discuss cancer, if you wish to use material which is simple and yet has teaching value for lay groups write to our Madison office and request the slides entitled 'Fight Cancer with Knowledge.'"

The office of the Society announces that it is prepared to supply a projector suitable for the showing of 2" x 2" slides, if one cannot be secured locally.

County Societies Urge Response To Current Health Legislation

Emphasizing the importance of keeping Congressmen in Washington duly informed as to the trend of public sentiment regarding current health legislation, the Outagamie County Medical Society added the following reminder to its monthly meeting notice: "P. S. Did you and your friends write your Senators and Congressmen regarding the Wagner–Murray–Dingell Bill? (S-1606) (HR-4730) Address your letter regarding S-1606 to Hon. Robert M. LaFollette, U. S. Senate, Washington, D. C.; Hon. Alexander Wiley, U. S. Senate, Washington, D. C. Address your letter regarding HR-4730 to Hon. John Byrnes, House of Representatives, Office Building, Washington, D. C."

"DOCTOR RATIONING! Do You Want it in Superior? headed a large ad appearing in the Superior *Telegram*, sponsored by the Douglas County Medical Society and eleven local drug stores. Following President Truman's message to Congress on the need for health legislation, the introduction of the Wagner–Murray–Dingell bill on November 19 of last year, with the concealed intention of placing in the hands of a federal government appointee sole and exclusive responsibility for the distribution of health care for one hundred ten million people, was declared to contain "instrumentalities and mechanisms of the Collectivist State." It was further stated that "If we are to preserve our Freedom of Enterprise we dare not enact these proposals into law."

In conclusion, there appeared the following statement: "This issue must be decided by the Congress of the United States. Members of Congress are entitled to know what the people of their districts think about these proposals. Talk or write at once to your Senators and Congressmen."

LAW REQUIRES LISTING OF WAGE DEDUCTIONS

The Wisconsin Legislature has passed a new law (Chapter 317, Laws of 1945). It read as follows:

"103.457 LISTING DEDUCTIONS FROM WAGES. An employer shall state clearly on the employe's pay check, pay envelope, or paper accompanying the wage payment the amount of and reason for each deduction from the wages due or earned by the employe, except such miscellaneous deductions as may have been authorized by request of the individual employe for reasons personal to himself. A reasonable coding system may be used by the employer."

Physicians are included under this act.

WISCONSIN PLAN LEADS

(Continued from page 2)

Assurance of a low premium rate schedule within reach of all is expected by executives of the insuring companies through the maintenance of competition between them. While the indemnities will be uniform, the policies will not be jointly underwritten, each participating company writing its own contract of insurance.

Membership in the California Health Insurance Conference is not limited to its present members, but has been opened to all companies licensed to do an accident and health insurance business in California, according to spokesmen of the Conference.

FIVE MEDICAL OFFICERS

(Continued from page 4)

to Salzburg and thence to Vienna as acting chief medical officer of UNRRA in Austria. In this post his work was chiefly concerned with refugees. He returned to the United States last January.

Among other duties with the Office of Vocational Rehabilitation, Doctor Newberry will devote special attention to the development of physical restoration services in Region I, embracing Maine, Vermont, New Hampshire, Massachusetts, New York, Connecticut, and Rhode Island, with regional offices in Boston.

Other medical officers named are: Drs. Thomas B. McNeely, New Orleans; Henry H. Kessler, Newark, N. J.; Hewitt Varney, Sheepshead Bay, N. Y.; and W. L. Mould, USPHS, Region VI.

Minnesota Plans Book On Public Health History

Minneapolis—Judge Kenneth G. Brill of St. Paul, president of the Minnesota Historical Society, announced today that the society has received a gift of $25,000 from the Mayo Properties Association, Rochester, Minnesota. The money will be allocated for use in the writing and publication of a "History of Public Health in Minnesota."

Minnesota, from its earliest days, has been a leader in the public health movement. Dr. Charles N. Hewitt, who came to Red Wing in 1866 after serving as a surgeon in the Civil War, was the trailblazer of the public health movement in Minnesota. It was his contention that Minnesota promote the fight for good health. Through his efforts, a Minnesota state board of health was established in 1872. Doctor Hewitt served as its head for twenty-five years. A magazine, *Public Health*, was started by him to further the efforts.

It took time to bring about public thinking along his proposed lines, but much progress was gained as years went by. Quarantine for contagious diseases was made compulsory; vaccination was demanded; pure food laws were passed; a war against diseases in livestock was organized, each effort a pioneer in itself.

With this background of pioneering in public health, the Minnesota Historical Society will, through this generous gift from the Mayo Properties Association, be able to record for the people of the state what has gone before in the dynamic history of the public health movement.

The story of this movement will be a major contribution to the history of Minnesota and its people. It will be of interest not only to the medical profession, but also to nurses, public officials, students of sociology and history, social workers, and a wide public.

Mr. A. J. Lobb, secretary of the Association stated that "the Board of the Mayo Properties Association appreciates the need for such a publication and the necessity for prompt action in order that the materials may be preserved and the story recorded by those now living."

The producing of the "History of Public Health in Minnesota," will open the way to monographs and special studies of aspects of the movement that cannot be dealt with in one general account. It will be important also as a contribution to a larger history of medicine in Minnesota which ultimately will be written.

The publication will be written in close cooperation with the State Department of Health and Vital Statistics, the Graduate School of the University of Minnesota, and the Department of History of the University.

The task of preserving for future generations the record of Minnesota's growth was entrusted to the Minnesota Historical Society ninety-six years ago this month by the pioneers of a wilderness territory itself newly formed. The society, the oldest incorporated institution in the state, has these many years collected and preserved the history of Minnesota and its people. The wealth of material gathered was not just stored to collect dust, but was collected so that information about the history of the state would be available for the writing of books such as that on public health envisioned by the Mayo Properties Association.

THE MARCH OF MEDICINE

NOTE: REVISED SCHEDULE

Ashland	WATW	Saturday	8:15 a. m.
Appleton	WHBY	Saturday	11:15 a. m.
Calumet, Mich.	WHDF	Saturday	8:15 a. m.
Eau Claire	WEAU	Wednesday	4:15 p. m.
Escanaba, Mich.	WDBC	Saturday	8:15 a. m.
Green Bay	WTAQ	Friday	3:45 p. m.
Ironwood, Mich.	WJMS	Saturday	8:15 a. m.
La Crosse	WKBH	Thursday	3:00 p. m.
Madison	WIBA	Saturday	10:00 a. m.
Manitowoc	WOMT	Saturday	4:30 p. m.
Marinette	WMAM	Monday	4:00 p. m.
Marquette, Mich.	WDMJ	Saturday	8:15 a. m.
Medford	WIGM	Friday	11:15 a. m.
Milwaukee	WEMP	Saturday	11:30 a. m.
Rice Lake	WJMC	Monday	2:45 p. m.
Stevens Point	WLBL	Monday	11:30 a. m.

FEDERAL FUNDS—

(Continued from page 2)

Based on a study made in two counties for the months of July, August, and September, 1945, a figure of $700,000 is given by the Division of Public Assistance as representative of the amount of federal funds, matched by state funds, spent on medical care. "Medical care" is interpreted as including hospitalization as well as cost for services of a physician and related needs. Milwaukee County was excluded from this estimate, however, because its procedure for providing medical care does not generally include an allowance in the recipient's grant to permit his making payments for such assistance.

The total federal funds used in Wisconsin for health purposes in the fiscal year 1946, according to the above allocations, amount to $2,109,490.

Loan Packets

The Office of the State Medical Society has available loan packets for lay or professional use on the subject of the Wagner-Murray-Dingell Bill and related matters.

The
MEDICAL FORUM

The Wisconsin Medical Journal June, 1946

UW REGENTS STUDY PROPOSED NEW LAB ON CAMPUS

COOPERATIVE HOSPITAL PROPOSED IN BARRON CO.

Members of a committee for the organization and establishment of a cooperative hospital to provide pre-payment medical care for several hundred members in Barron County, through newspaper stories and editorials, are bitterly protesting the "Enabling Act" passed by the Wisconsin State Legislature in July, 1945. They claim the State Medical Society and its county societies secured authority to establish sickness-care plans which does not include lay cooperative organizations.

Only insurance companies were permitted by law to conduct prepaid plans on an insurance basis. The "Enabling Act" permitted the establishment of pre-payment medical insurance by the State Medical Society and its affiliated County Medical Societies. It specifies that any plans by the Societies be subject to the state insurance laws concerning premium reserves, investments, and non-discriminatory rates, with policy forms subject to commission approval.

Hospital Organization

The plans for the organization of the Barron County Cooperative Hospital have been underway for quite a while. The organization of the hospital called for a minimum membership of 2,000 at $50 per membership. This money raised would permit construction of the hospital. Additional fees yearly would supply complete hospital and medical care for the families of the members owning a part in the hospital. This would enable people in the low income groups to receive medical care at a low cost.

According to reports, after drafting plans, the members of the board of the proposed cooperative hospital discovered the plan could not be carried through under present laws.

(Continued on page 4, column 2)

DR. A. R. ZINTEK AWARDED RESEARCH FELLOWSHIP

Dr. Arthur R. Zintek, State Board of Health staff member on leave of absence, has been granted a year's fellowship by the National Foundation for Infantile Paralysis to continue training and research on poliomyelitis and other virus diseases at the School of Public Health, University of Michigan.

A. R. ZINTEK

The fellowship permits Doctor Zintek to complete a two-year training program, at the conclusion of which it is anticipated that he will be appointed director of the Bureau of Preventable Diseases, the State Board of Health has revealed. Dr. H. M. Guilford, present incumbent, will reach compulsory retirement age in 1948.

Doctor Zintek began his special training in epidemiology in June, 1945, when the board granted him a year's leave of absence at the Ann Arbor institution to accept a fellowship of the Commonwealth Fund. His significant work on polio and other virus diseases led to the award of another year's training by the National Foundation for Infantile Paralysis.

The special training program for the proposed department head is part of the plan of the State Board of Health for more effective epidemiologic work of the Preventable Disease section in collaboration with the proposed enlarged laboratory facilities for the state.

Space Needed For Research, New Programs, and Laboratory Animals

Madison — Better laboratory service to Wisconsin's practicing physicians and better control and prevention of disease are closer to realization now that the Board of Regents of the University of Wisconsin and the State Board of Health have before them a joint agreement for the construction and operation of a new enlarged State Laboratory of Hygiene.

Plans now under consideration call for the construction of a new laboratory building and barn for laboratory animals, to be located near the University Medical School on land allocated by the regents. The 1947 state legislature will be asked to appropriate an estimated $600,000 for construction and equipment of the new laboratory building and $50,000 for the animal barn.

The agreemnt for construction and operation of the new and enlarged facilities was drawn up by a committee representing the Board of Regents, the University Medical School, the Campus Planning Commission, the State Board of Health, and the State Medical Society.

Dr. W. D. Stovall, director of the State Laboratory of Hygiene, has repeatedly pointed out that Wisconsin's laboratory facilities have long been outgrown. Present space occupied is the same as in 1928, while the number of specimens examined has increased nearly 400 per cent.

The joint agreement outlines the need for additional public health laboratory facilities and services as follows:

1. To more adequately meet the present public health laboratory

(Continued on page 6, column 1)

New Jersey Plans Cash Temporary Disability Aids

State C. of C. Opposes Plans Such as Rhode Island System

Reviewing the problem of cash temporary disability benefits, and vigorously opposing any legislation which does not consider the fundamental principles of their suggestions, the Social Security Committee of the New Jersey State Chamber of Commerce appeared recently before the State Commission on Post-War Economic Welfare of New Jersey, recommending:

A. Monopolistic state-administered plans (of which the Rhode Island system is an example) are not as efficient nor economical as non-governmentally administered plans.

B. To facilitate competent supervision, provisions should be clearly made, and the application of the experience rating principle is essential.

C. Employers and employees should share the program cost.

D. Benefits should be payable *only* to those who suffer a *loss of earnings* due to a temporary disability.

E. The cash temporary disability program should not supplement workmen's compensation payments, i. e., benefits should not be payable under both programs for any disability compensable under the Workmen's Compensation Law.

F. Reasonable eligibility requirements should be provided with a bridging of benefit rights reasonably of eligible employees during interruptions in employment.

G. Reasonable ineligibility provisions should be made in the event disability arises out of self-inflicted injury, as a result of unlawful acts, for failure to undergo medical examination, or in the event there has been fraud in connection with the claim filing.

H. There should not be less than one week waiting period in respect to each period of disability.

I. Benefits should be related to recent wages earned by the employee, under a cash temporary disability benefit program.

J. Weekly benefits given should approximate 50 per cent of recent wages with reasonable minima and maxima as to duration and weekly amounts.

STATE C. OF C. COMMITTEE MAKES RECOMMENDATIONS

Recommending that unemployment compensation coverage be extended to all employers of one or more where the state law now covers the occupation and industry, the Social Security Committee of the State Chamber of Commerce, meeting in Milwaukee on May 24, formulated its position on the revision of this law.

The committee also suggested that government workers be likewise covered, although expressing its opinion that administrative difficulties would have to be overcome and provisions made for the federal government to reimburse the states in full for the benefits paid to federal workers.

Return Employment Offices

The committee recommended the U. S. Employment Offices be returned to the states immediately. During the war emergency these services were loaned to the federal government. Another suggestion offered was that no group nor class should have separate or special legislation—all workers in the various industries should be covered by like provisions of social security.

Those present at the meeting were: Marvin Verhulst, Charles H. Crownhart, Lowell Whittet, Carl Jacobs, P. M. Chiuminatto, E. L. Wingert, Clarence Klocksin, and W. J. Petersen.

WISCONSIN LOW IN TUBERCULOSIS DEATHS

According to information recently released by the U. S. Public Health Service, studies of tuberculosis death rates, by state, for 1944, 1943, 1942, and 1939–41 (average), show Wisconsin consistently in the lowest nine.

In 1944 the death rate per 100,000 population for Wisconsin was 24.4, with that for the entire United States, 41.3. The relatively low tuberculosis mortality area extends from Wisconsin to the Pacific Northwest with New Hampshire the only state in the East in the lower quartile. For the years recorded in the release, Utah has

(Continued on page 5, column 2)

DOCTOR TENNEY REPORTS ON CHILD HEALTH STUDIES

"When the one-page questionnaires sent to each physician in the state (with the exception of Milwaukee County physicians who will receive their questionnaires in a few months,) are returned," Dr. H. Kent Tenney Jr., State Chairman of the Wisconsin Child Health Study, reports, "Wisconsin will have available for the first time a complete picture of what care is offered for children by the medical profession within the state."

H. Kent Tenney

He continued, saying that to gather more information for the studies, dentists throughout the state will be contacted about the services they are giving to children. The studies will also include information on care for children available in all hospitals: general, orthopedic, pediatric, maternity, and nervous and mental hospitals. Tuberculosis sanatoriums and preventoriums, convalescent and chronic hospitals, rest homes, nursing homes, and contagious hospitals will also be contacted.

Completing the program, studies will be made of Medical Well-child Conferences, Dental Services for Children, Mental Hygiene Services for Children, Health Services for Physically-handicapped Children, Communicable Disease Control, School Health Services, Public Health Nursing Services, and other allied services offered to children.

"As you can see," Doctor Tenney concluded, "this is a tremendous undertaking and will need cooperation both in the answering of the questionnaires and in encouraging the people in other fields to send in the needed information."

The irrepressible Irene Castle McLaughlin is at it again. During the past legislative year physicians will recall that this noted lady appeared before an assembly committee to argue the case of the antivivisectionists.

Her latest effort is an endeavor to organize "humanitarians" to inscribe a bronze plaque to William Randolph Hearst for his "outstanding, fearless defense of animals, and untiring efforts to relieve their suffering." Wisconsin, says Mrs. McLaughlin, should be represented in the formation of this award.

* * *

About a year ago the Committee on Health and Public Instruction authorized the preparation of a special health news release for the Wisconsin Agriculturist and Farmer, a Racine publication that has a tremendous circulation among the farmers.

One sometimes wonders what value there is to these efforts—but a survey conducted by the publication dispelled all doubts. Four hundred farm people in 19 counties of the state were surveyed on "reader interest". Thirteen per cent of the men, and 35.9 per cent of the women had read the current Society article. By comparison, the Society lost to the columns on poultry, jokes, and veterinary matters so far as the men readers were concerned, but scored heavily over these columns for the women readers.

* * *

There is interest in the statement attributed to John W. Bricker, former Ohio governor, and Republican candidate for vice-presidency in 1944, who has endorsed extension of the hospital care plans into the fields of medical and surgical service. He has said to have asserted that he sees "every reason why this cooperative movement, voluntary and private in character, should extend into the field of medical and surgical service."

Various insurance associations are freely prophesying that beginning next January when the bulk of legislative bodies assemble, many states will see the introduction of cash sickness bills. California now has such a law, but permits an employer to self-insure or to take insurance with a private carrier. Rhode Island's law is compulsory also, but fails to provide an alternative means for a voluntary plan.

* * *

Some insurance company executives now argue that insurance companies in the accident and health business should draft a bill permitting private carriers to participate in a compulsory plan, in which the employer would be required to provide non-occupational accident and sickness insurance for his employees.

* * *

On the other hand, many executives apparently believe that it is all right to accept the compulsory principle when it comes to occupational injuries, but it is quite another thing to propose such a principle in matters which have no direct relationship to employment. Some wonder what effect the current labor situation will have on this, for in at least one dispute, it is urged that a health and welfare fund be a requirement of the contract.

* * *

Children's Bureau in Washington has been stirring things up through the public press again. At a recent meeting of the Advisory Committee on the Care of Crippled Children Mr. Frank Powell, director of the Bureau of Handicapped Children, reported that a flood of requests for use of state funds for the purchase of hearing aids has reached his office as a result of press releases over the name of the Children's Bureau indicating that state and federal funds are available for such purposes.

Mr. Powell is a person who desires to serve the handicapped people of Wisconsin, but he questions the wisdom of agencies in Washington holding out promises which his department is asked to fill.

The acceptance of hard-of-hearing cases under the classification of handicapped persons entitled to purchase of hearing aids through state funds would throw a heavy load on the Bureau of Handicapped Children, and would present a medical problem of prescription of devices which Mr. Powell feels should correctly be accomplished through medical specialists.

LICENSURE APPLICANTS EXAMINED BY BOARD

The State Board of Medical Examiners, meeting at the Loraine Hotel in Madison, June 20, 21, and 22, examined twenty-seven applicants for license to practice medicine. Twenty-nine applicants for licensure by reciprocity were examined.

The public appetite is frequently whetted through Washington agencies which seek every means of stimulating public demands for service to enlarge their bureaucratic organizations. And when state agencies or organized medicine resist such an approach to medical problems they are commonly branded as obstructionists by those who welcome any form of governmental subsidy.

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Fellowships Offered in Public Health Through Grant of National Foundation

Not Open to Present Employees of State and Local Agencies

Washington, D. C., May 23—Announcement is made by Surgeon General Thomas Parran of the U. S. Public Health Service that a grant for the establishment of 125 Fellowships to train physicians and sanitary engineers in public health has just been approved by the National Foundation for Infantile Paralysis.

"Wisconsin needs more trained people to carry on public health work. Therefore the State Board of Health welcomes any measure which will help to provide qualified personnel for essential public health positions," was the comment of Dr. Carl N. Neupert, State Health Officer, when interviewed about the fellowships. Six districts are without medical health officers and a number of vacancies exist in the medical staff in Madison, he pointed out.

Each Fellowship provides a year's graduate training in a school of public health or a school of sanitary engineering. The Fellowships will be administered by the Committee on Training of Public Health Personnel, which consists of representatives of schools of public health, the State and Territorial Health Officers, the American Public Health Association, and the U. S. Public Health Service.

The Fellowships are available either during the academic year beginning in the fall of 1946 or the fall of 1947, and are open to men and women, citizens of the United States under 45 years of age.

The purpose of the Fellowships is to aid in the recruitment of trained health officers, directors of special medical services, and public health engineers to help fill some of the 900 vacancies in public health medical positions and 300 vacancies for public health engineers, existing in state and local health departments over the country. The Fellowships are reserved for newcomers to the public health field, and are not open to employees in state and local health departments, for whom Federal Grants-in-Aid are already available to the states.

Applicants for Fellowships may secure further details by writing to the Surgeon General, U. S. Public Health Service, Attention: Public Health Training, 19th and Constitution Avenue NW., Washington 25, D. C. Owing to the anticipated heavy enrollment in graduate schools, completed applications for training in the fall term of 1946 should be filed promptly. The awards committee will act on applications on the following dates: June 15, July 1, July 15, and August 1.

COOPERATIVE HOSPITAL

(Continued from page 1)

Prepare to Fight

The Barron County Cooperative Hospital committee is now preparing to fight the issue, and probably will attempt to secure legislation for a separate enabling act that will apply to consumer cooperative groups. An article in the Burnett County Leader, Siren, May 9, includes a letter from Mr. A. V. Bodeen, chairman of the hospital board. Arguing for permission for cooperatives to establish pre-paid medical care projects, Mr. Bodeen says, "It just seems to me that this is much bigger than just trying to build another hospital. It is in the first place trying to provide means whereby people can provide medical facilities where the medical profession has failed in the past. Secondly, by so doing, we are certain of a health program the nation over, because it's a preventive program rather than a cure, and thirdly, it will do these things at a price which is within the reach of everyone."

Mr. Bodeen continued, saying that draft statistics of this past war—half of the first three million men examined medically were rejected because of some physical defect—show the absolute need for more service in health programs.

Claim a Monopoly

Barron County newspaper articles claim the "Enabling Act" gave the State Medical Society a monopoly on establishing sickness-care plans, but when Governor Goodland signed the bill in August, 1945, he gave assurance that the bill "does not create a monopoly on the part of the societies."

MARCH OF MEDICINE GUEST SPEAKERS

The March of Medicine radio series last fall instituted a policy of presenting occasionally on its programs guest speakers.

Dr. William J. Bleckwenn, former consultant in neuropsychiatry, Headquarters, Sixth Service Command, now returned to the staff of the Wisconsin General Hospital, gave two speeches directed to servicemen's families about adjustment of the returning men, cautioning, "It is most important that our home front realize that a handout, charity, or pension is *not* the answer to the ex-serviceman's security."

"Surprising as it may sound, there is good evidence now that in spite of food shortages, rationing, etc., there was a definite improvement in the diet of most people in this country during the war years," declared Dr. Philip P. Cohen, associate professor of physiological chemistry at the University of Wisconsin, in his informal talk entitled, "Good Eating and Good Health."

Another program consisted of an interview with Colonel Leo Levenick, director of the Wisconsin Department of Veterans Affairs, conducted by Dr. Harold M. Coon, superintendent of Wisconsin General Hospital, in which Colonel Levenick discussed the details of emergency medical care available to veterans.

Dr. William D. Stovall, director of the State Laboratory of Hygiene, took part in an interview with Dr. Llewellyn R. Cole, director of the series, in which he described the work of the laboratory. He also gave two talks on cancer, one entitled, "Sunlight Cancer."

In speaking on "Good Prenatal Care Guards Mother and Baby," Dr. Carl N. Neupert, State Health Officer, showed that in Wisconsin in 1920, seven mothers died in childbirth for every thousand babies, and that in 1944 less than two lost their lives for each thousand births. This decrease in deaths was achieved through improvement in prenatal care.

Dr. Elmer L. Sevringhaus, formerly of the staff of the University of Wisconsin, who spent several months in Italy as clinical director of the Italian Medical Nutrition Mission, with UNRRA,

(Continued on page 5, column 2)

ANNUAL MEETING *News*

105th ANNUAL MEETING
MILWAUKEE, OCTOBER 7-8-9
STATE MEDICAL SOCIETY of Wisconsin

Milwaukee, Oct. 7–8–9

■ **WHITE, PHEMISTER TO SPEAK:** Tuesday, October 8 will feature section meetings in the morning and a wide variety of professional papers during the afternoon general session. Out-of-state speakers who will participate in the afternoon session are Paul D. White, Boston, who will present a paper on *The Most Important Therapeutic Measures in the Treatment of Hypertensive Heart Disease;* and Dallas B. Phemister, Chicago, who will speak on *The Treatment of Ununited Fractures by Bone Graft Without Tie or Screw Fixation.* The same afternoon D. Murray Angevine, newly associated member of the Wisconsin Hospital staff, Madison, and formerly of McGill University, Toronto, will speak on *Hemorrhagic Nephrosis Due to Transfusion Reactions;* Dr. Theodore C. Erickson, Madison, will present a clinical demonstration on *Protrusion of the Intervertebral Disc;* and Francis R. Janney, Wauwatosa, will present a paper on *Advances in the Diagnosis and Treatment of Some Pediatric Conditions.*

* * *

■ **VETS RECEPTION TO REPLACE SMOKER: The customary Monday evening Smoker will be replaced by a special reception and social hour presented to returning veteran members, with officers and Councilors of the State Society as hosts. It is intended that a program of entertainment will be arranged by a special committee, in cooperation with the Secretary's office.**

* * *

■ **ROUND-TABLE LUNCHEONS LIMITED TO FIFTEEN EACH DAY:** A scarcity of dining room space has necessitated the limitation of noon round-table luncheons to 15 each day of the annual meeting. All round-table leaders have been secured by Dr. E. R. Schmidt, Madison, general program chairman. Members will receive a brochure and reservation slip in late July.

Kiddie Camp Drive For Child Rheumatic Fever Home

MARCH OF MEDICINE—

(Continued from page 4)

gave a talk about food conditions in Europe.

Child behavior problems were discussed by Dr. Eugenia S. Cameron, director of mental health with the State Board of Health, in two speeches. "It is in the home and largely from the parent-child relationships that a child learns a way of life," Doctor Cameron emphasized.

Speaking of rheumatic fever in an interview program conducted by Doctor Cole, Dr. Chester Kurtz associate professor of clinical medicine at the University of Wisconsin, described the symptoms, proper care necessary, and warning about complications, of the disease.

Departing from the usual procedure of presenting only medical men and women as guest speakers, one program included a talk by Mr. Robert W. West, director of speech pathology at the University of Wisconsin, on the subject of speech defects, and another was devoted to a speech about the various services available for children with physical handicaps, presented by Mr. Frank V. Powell, director of the Bureau for Handicapped Children.

The first personal appearance on any program of the March of Medicine was made on WEMP, Milwaukee, by Dr. Eben J. Carey, dean of the Marquette University Medical School, on the Saturday proceeding the Milwaukee Centennial Celebration. Doctor Carey discussed the medical programs and exhibits in connection with the celebration.

WISCONSIN LOW—

(Continued from page 2)

consistently had the lowest death rate per 100,000 population of any state. The high death rate area for the disease runs down from Nevada through the South to Kentucky, and also includes Maryland and New York.

The mortality rates given by areas are not wholly influenced by environment, efforts to prevent tuberculosis, or equipment available for care of those with the disease, but also by differences in reporting of cases; age, race, and sex of population; and during the war years, by the great movement of population and large numbers serving in the armed forces.

Board Discontinues Camp For Child Tuberculosis Cases

Madison—Due to the emphasis upon a crusade against rheumatic fever, exerted by state health and educational authorities, and physicians, and due also to the decline in the number of tuberculosis cases among school children, as shown by Madison Board of Health statistics, the board of the Kiddie Camp, Madison, has altered its projects. Discontinuing the tuberculosis preventorium camp held each summer, the board will conduct a drive for funds to construct a year-round home for young convalescent rheumatic fever victims. The need for such a home is great.

The Madison Convalescent Home for Children with Rheumatic Fever, managed by the Bureau of Handicapped Children of the State Department of Public Health Instruction, and aided by a federal grant for expenses in administration and individual contributions, was started two years ago. Directed by Mr. Frank Powell of the State Department of Public Instruction, and medically supervised by Drs. Chester Kurtz, Kenneth McDonough, and H. Kent Tenney, the home has cared for over fifty children. It has a fifteen bed capacity, but at present, over thirty children need the care it offers. Continuously there has been a long waiting list for admittance. It is inadequate for the large number of child rheumatic fever patients in this area.

State educational and health authorities and physicians say that rheumatic fever kills more children than measles, whooping cough, scarlet fever, meningitis, and infantlie paralysis combined. According to Metropolitan Life Insurance statistics Wisconsin is one of three states in the region second highest in the occurrence of rheumatic fever among children in the nation.

Consideration of all these facts has caused the Kiddie Camp directors to commence their drive in an attempt to alleviate the dangerous shortage of homes for child rheumatic fever convalescents.

Civilian Amputees Receive More Aid From OVR

U. W. REGENTS—

(Continued from page 1)

load in connection with certification of inter-state water supplies and the increasing volume of requests for drinking water analyses and for normal growth.

2. To provide for new programs such as the establishment of a state-wide blood plasma bank, and for studies of virus diseases and diseases of the intestinal tract, in coordination with the problems in epidemiology coming before the State Board of Health in connection with the spread of influenza, poliomyelitis, food poisonings, dysenteries, etc.; industrial hygiene; enlarged water pollution control activities; enlarged tuberculosis control program; and the development of biologics including the fractionation of globulins and the preparation of vaccines (typhoid, etc.)

3. To provide for research in the field of reinvestigation of problems for the improvement of laboratory technics now in use; and for investigation of technics that have been suggested but not yet tried out, such as gonococcus cultures, new whooping cough plate technic, etc.; and for investigating fundamental biological problems having to do with the spread of disease.

Milwaukee—"The lot of the civilian amputee suffers today in comparison with that of the returning service-man-amputee because until a year or so ago the planning and organization for his welfare could not begin to match those of the armed forces," declared Dr. Henry H. Kessler, recently appointed consultant in orthopedics and prosthetic devices to the Federal Office of Vocational Rehabilitation, when he spoke to the staff of the Wisconsin Rehabilitation Division at a luncheon meeting in the Hotel Schroeder, Milwaukee, on April 26.

Among Doctor Kessler's first projects will be one to start a five-point program to aid the 30,000 to 70,000 civilians who annually undergo amputations, providing psychological treatment, adequate surgery, after-care of the stump, proper limb fitting, and instruction in use.

"A civilian amputee who is about to use an artificial limb for the first time needs a middleman between himself and the manufacturer. There is no reason why he should be shunted from salesman to salesman or from store to store," Doctor Kessler continued.

"He should be shown the shortcomings and advantages of the various types of artificial limbs in order that he may select the appliance which best suits his particular need.

Same Service as to Vets

"We want to give the civilian amputee the same type of service which our returning servicemen are receiving. Instead of having an amputee fending for himself on a hit-or-miss basis, we propose to furnish him with psychological treatment to adjust him to his new condition, assist him in selecting the proper type of artificial appliance and then see that he receives the proper instruction to derive the best possible vocational benefit."

At a meeting the evening of April 26, Doctor Kessler gave a more technical speech before the staff and other groups, among them occupational therapists, Veterans Administration counselors and public health nurses, discussing the surgical technic of cineplasty and the progress of development of prosthetics during the war.

New Missouri Legislation On Wide Use of Prefix "Doctor"

Act Covers Chiropractors and Optometrists Among Other Groups

The Missouri Legislature has passed a "Doctor Prefix Bill," which prohibits any person licensed in that state ". . . to practice medicine, surgery, dentistry, optometry, osteopathy, chiropractice, chiropody, or veterinary surgery . . ." or any person ". . . permitted by law to practice the curing, healing or remedying of ailments, defects or diseases of body or mind with or without a license . . ." To use the prefix "Dr." or "Doctor" with his name in any written material—stationery, prescription blanks, signs, advertisements, or displays, without giving the degree held by him or the name of the type of practice in which he is engaged, according to the Journal of the Missouri State Medical Association.

However, section two of the act states that the act does not prohibit the use of that prefix by a person who holds a degree such as, doctor of law, doctor of science, doctor of letters, etc., that does not involve the curing of illness of the body or mind.

Section three of the "Doctor Prefix Bill" provides that persons violating the provisions of the act will be guilty of a misdemeanor and convicted, will be fined five hundred dollars or be confined in the county jail for not more than six months, or both. Every day of violation of the act will be a separate offense and carry the same punishment.

Group Practice in Medicine Discussed By New York M. D.

"In order to be considered a medical group practice unit, an association of physicians of different skills, using medical equipment and nursing, technical and administrative personnel in common, must have a formal pattern of professional collaboration, a definite relationship as a group with a hospital or hospitals in the community, and a unified administrative and financial organization," Dr. Kingsley Roberts of New York declares, discussing group practice in a pamphlet entitled, "Solo or Symphony" recently issued by the Medical Group Practice of Medical Administration Service, Inc.

In the pamphlet, which consists of the correspondence between Doctor Roberts and an Army Medical Corps man expecting release from duty, Doctor Roberts claims that the advantages of group practice include professional cooperation among doctors without economic competition, increased economy and efficiency due to common use of facilities and shared costs, the value of consultation among doctors on cases, rotation among group

(Continued on page 8, column 2)

Denver Rehabilitation Home Aids Child Asthma Patients

Providing care for underprivileged children suffering from acute bronchial asthma and other refractory upper respiratory diseases, the National Home for Jewish Children at Denver is available to children from all over the country whose families cannot afford extensive and costly private care.

Commenting on the work of the institution, *The Journal of the American Medical Association* said, in a recent issue: "The children remain until physicians recommend that they be returned to their homes. In a comparatively normal environment, and sharing the companionship of other children, the asthmatic child is under expert medical supervision at the home and is cared for by a staff trained in child welfare. During his stay, periodic examinations are made and full reports given to the referring physicians and hospital clinics.

Modern Infirmary

"The National Home has a modern, well equipped infirmary where children requiring bed care are attended by registered nurses under the supervision of the attending physicians. The children are housed in attractively furnished congregate-cottages with individual bedrooms. Food of the highest quality is carefully prepared in modern kitchens, and special diets are given when prescribed by physicians. The children participate in the community life by attending the local schools and taking part in communal recreations. In addition to the intensive preparation made prior to the child's admission to the home, an equally thorough aftercare program is carried out on the return of the child to his family."

Application may be made by communicating with the Social Service Department of the National Home for Jewish Children, 1457 Broadway, New York 18, or through the office of the Jewish Social Service organization in any community.

Kradwell Foundation Forms in Wauwatosa

Wauwatosa, May 29—With the promotion of public health through the advancement of medical sciences, particularly in the fields of psychiatry, neurology, and allied branches of medicine, as its purpose, the Ada P. Kradwell Foundation is being formed in Wauwatosa, G. H. Schroeder, vice-president and treasurer, announced today.

Articles of Organization of the foundation, created by Dr. William T. Kradwell in memory of his deceased wife, have been filed with the Secretary of State, Mr. Schroeder explained. The diagnosis, treatment, care, and cure of persons suffering from psychiatric, neurologic, or related diseases will be undertaken at the foundation, and such expenses incurred by patients, who in the opinion of the Board of Directors are unable to pay, will be assumed by the foundation.

Scholarships, Fellowships To Be Offered

The foundation also plans to establish fellowships and scholar-

(Continued on page 8, column 1)

ATTORNEY GENERAL RULES ON PAYMENT TO OPTOMETRISTS OUT OF STATE FUNDS

RULING ALLOWS PAYMENT TO MOST OSTEOPATHS AND ALL MDS

Declaring that it is not proper to include an optometrist in state reimbursement to the extent of 35 per cent for "medical or surgical and hospital and nursing home care," granted by the social security aid agencies in the various counties according to sec. 49.03 (1) (c) of the Wisconsin Statutes, 1945, the Assistant Attorney General in Madison, reports that the practice of optometry is governed by Chapter 153 of the statutes and does not include practicing of surgery or administering drugs or medicine.

He states that dentists and osteopathic physicians and surgeons, with the exception of some older surgical osteopaths not licensed to practice surgery, *are* authorized for the state reimbursement by social security aid agencies.

The State Medical Society, in cooperation with the Historical Museum, presented a display of old instruments and medical supplies at the Centennial Celebration of the Medical Society of Milwaukee County in late April and early May. It is hoped that a similar type of exhibit, on an enlarged basis, can be offered at the Annual meeting in October.

POLIO PREPAREDNESS CONFERENCE HELD

The second annual polio preparedness conference was held in Milwaukee, June 4–5 at the Pfister Hotel. Physicians and health officials attended the first day's sessions, while the second day was devoted to sessions for representatives of the Wisconsin county chapters of the National Foundation for Infantile Paralysis.

One of the highlights of the conference was the report of Dr. Fred Welch, city health commissioner, Janesville, on the panic in his city when the polio epidemic raged in nearby Rockford. He told of the terrific pressure from laymen to have unsound control methods adopted, such as the closing of taverns. Janesville had no polio until December, when two cases occurred, both in children.

Enforce State Regulations

Dr. Carl N. Neupert, State Health Officer, again told the assembled physicians and health officers to resist unsound control measures which merely appease a frightened public. He urged all communities to enforce the state regulations for the prevention and control of polio.

Dr. Hart E. Van Riper, New York, former Madison physician, now acting medical director for the National Foundation, urged that all hospitals be opened to polio patients, with confinement in an isolated wing.

KRADWELL FOUNDATION

(Continued from page 7)

ships for young physicians who, having completed their internships, desire further training in neurology, psychiatry, or related branches of medicine, or wish to pursue scientific research projects for graduate degrees at medical schools accredited by the American Medical Association. Publication through exhibits, books, talks, and radio addresses, of scientific results obtained through this work is planned.

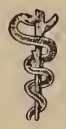
The officers of the foundation are: Dr. William T. Kradwell, president; G. H. Schroeder, vice-president and treasurer; and Leon F. Foley, secretary.

AMA SESSIONS
San Francisco
July 1 to 5, 1946

CERTIFICATES AWARDED STATE RADIO STATIONS

Madison May 21—Certificates of merit were awarded as recognition of service rendered to the public by presenting The March of Medicine weekly for a year, to radio stations: WATW, Ashland; WDSM, Superior; WEAU, Eau Claire; WIBA, Madison; WIGM, Medford; WJMC, Rice Lake; WJMS, Ironwood; WKBH, La Crosse; WLBL, Stevens Point; WMAM, Marinette, and WOMT, Manitowoc, by the State Board of Health in cooperation with the Medical Society which sponsors the series, the State Medical Society announced today.

The signatures of Dr. Gunnar Gundersen, La Crosse, and Dr. Carl N. Neupert, Madison, president and secretary of the State Board of Health, and Dr. P. R. Minahan, Green Bay, and Mr. C. H. Crownhart, Madison, president and secretary of the Medical Society, appear on the certificates.



CERTIFICATE OF MERIT

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THE STATE BOARD OF HEALTH

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in recognition of the public service rendered the citizens of Wisconsin by presenting each week for one year

THE MARCH OF MEDICINE

Issued this _____ *day of* _____ *19*___

THE STATE BOARD OF HEALTH	THE STATE MEDICAL SOCIETY
PRESIDENT	PRESIDENT
SECRETARY	SECRETARY

GROUP PRACTICE—

(Continued from page 6)

of routine work, and assurance of regular secure incomes.

According to the doctor there are several types of group practice which might interest doctors returning from service who enjoyed working with other medical men as a group while in the armed forces: reference groups such as the Mayo Clinic; diagnostic groups, such as the diagnostic clinic at Johns Hopkins, Baltimore; and service groups, which offer general family care or specialists services.

The
MEDICAL FORUM

The Wisconsin Medical Journal July, 1946

SOCIETY DELEGATES ESTABLISH STATE SOCIETY PREPAID MEDICAL PLAN, COMMITTEE APPOINTED

Report of Committee on Veterans Adopted

Without dissenting vote, the report of the Committee on Veterans was adopted by formal House of Delegates action meeting June 22, in Madison. The Council authorized the Committee on Veterans, composed of Doctors Finn, Hardgrove and Supernaw, to undertake immediately completion of the arrangements suggested by the committee and report back to the House, at earliest possible date, for ratification.

The resolution in full follows:

A Resolution

Resolved, That the House of Delegates of the State Medical Society of Wisconsin on the authority of its Constitution and By-Laws, and also on the authority contained in Chapter 148, Wisconsin Statutes, create the Veterans Medical Service Agency as an official agency of this Society.

Such agency shall be under the general direction of the Society and its membership shall be geographically representative of the profession in the state. The agency shall be organized and developed by the Council.

This agency will be empowered to contract with the Veterans Administration for the physical examination, treatment and medical care of veterans and with state and other agencies authorized by law to administer the various medical and other programs designed for veterans.

This agency shall be further empowered to contract with physicians and others in carrying out the functions assigned it, to provide for administrative procedures necessary thereto, and, on behalf of the Society and subject to direction of the Council and the House of Delegates, to conduct all such business of said agency.

DR. DEXTER H. WITTE HEADS SPECIAL COMMITTEE TO REPORT PLAN

Punctuated by lively debate, the House of Delegates of the State Society in special session on June 22, in Madison, acted to establish a second state-wide plan of prepaid medical care in Wisconsin. Adopting, after amendment a report of the Resolutions Committee, based upon a resolution offered by Dr. H. Kent Tenney of Madison, on behalf of delegates from the Third Councilor District and several county societies, the House of Delegates sought the cooperation of the Medical Society of Milwaukee County "in developing this state-wide program which would, as soon as possible, absorb Surgical Care of Milwaukee County."

Creating a special committee of the House to arrange for the establishment of the plan, the House provided that three of the nine members should be recommended by the Milwaukee County delegates from the Medical Society of Milwaukee County, with one to be appointed from among the membership of the Racine or Kenosha County Societies, the balance to be appointed from the state at large.

Approval was given to the "manner of establishment" of the Surgical Care Plan of Milwaukee County, and previous action of the House in 1940, disapproving the Blue Cross Plan for its incorporation of certain medical services in its hospital contract, was rescinded.

The special committee of nine physicians appointed to report the plan and the arrangements for absorbing Surgical Care is headed by Dr. Dexter H. Witte, Milwaukee, a councilor of the State Medical Society, and for some period of time chairman of its Committee on Medical Economics and Voluntary Sickness Insurance. Other appointments made by Dr. E. C. Cary, Reedsville, speaker of the House, and ratified by the House, included: Drs. Jerome W. Fons, Milwaukee; J. W. Truitt, Milwaukee; W. C. Stewart, Kenosha; L. V. Littig, Madison; Gunnar Gundersen, La Crosse; A. T. Nadeau, Marinette; E. M. Dessloch, Prairie du Chien; and C. O. Vingom, Madison.

D. H. Witte

Immediately following House adjournment, the Council of the State Medical Society provided $2,000 to finance the work of the committee, and approved the recommendation that R. F. Weber, executive assistant of the State Medical Society, be delegated to serve as secretary of the committee.

The entire resolution as adopted by the House follows:

Resolution of the House of Delegates Adopted Saturday, June 22, 1946

In view of the belief of the Milwaukee Society that Surgical Care should be expanded outside of Milwaukee County, we favor action

(Continued on page 2, column 1)

PREPAID MEDICAL PLAN

(Continued from page 1)

by this House of Delegates to establish on a state-wide basis, and through our State Society, a plan of prepaid medical care of the character of Surgical Care of Milwaukee County. We also favor this House going on record in appreciation of the devoted and arduous labors of the Medical Society of Milwaukee County in the field of experimental prepaid medical insurance. In view of this experience we seek its cooperation in developing this state-wide program which would, as soon as is possible, absorb Surgical Care of Milwaukee County.

We, therefore, offer the following resolution:

Resolved that,

1. The House of Delegates create a committee to arrange the establishment of a state-wide prepaid medical care organization of the character of Surgical Care, this committee to arrange for the absorption of Surgical Care of Milwaukee County at the earliest feasible time, the proposed plan to be mailed to the delegates and alternate delegates not less than ten days prior to the next annual session of the House.

2. This committee shall be composed of nine members to be appointed by the speaker of the House, three members from recommendations from the delegation of Milwaukee County, one from Racine and Kenosha counties, and five from the state at large outside of Milwaukee, Racine, and Kenosha counties, all appointments to be ratified by the House of Delegates.

3. The plan be so devised as to permit it to be sold in conjunction with the Blue Cross plan of hospitalization, that the divorcement action of the House of Delegates in 1940 with respect to separation of the State Medical Society and the Associated Hospital Service, Inc. be rescinded.

4. This House of Delegates approve the "manner of establishment" of the Surgical Care plan of Milwaukee County.

5. This House of Delegates urge the whole-hearted cooperation and support of all physicians with the plan authorized under this resolution, as well as their continued cooperation with the Wisconsin Plan.

HOUSE ACTS TO ENDORSE RESOLUTION AGAINST WAGNER-MURRAY-DINGELL BILL

The House of Delegates, meeting in special session on June 22, heard the report of Dr. James O. Sargent of Milwaukee, concerning his appearance on the Wagner–Murray–Dingell Bill the previous day in Washington. After consideration of this report, the House adopted the following resolution against the Wagner–Murray–Dingell Bill:

WHEREAS, In the hearings on S. 1606 it becomes increasingly evident that a concerted effort is being made by its proponents to create the impression that the medical profession of the country is seriously divided on the issues involved through the use of numerous individual physicians and small groups of physicians admitted to appear in favor of the bill,

Be it resolved, That this House of Delegates of the State Medical Society of Wisconsin sitting in special session at Madison, this 22nd day of June, 1946, representing as it does 2700 physicians throughout the state of Wisconsin record its considered judgment that proposed legislation such as that of S. 1606, if ever enacted, would seriously jeopardize the proper and adequate care of sick people in America, and be it further

Resolved, That a copy of this resolution together with a true record of the Aye and Nay votes be forwarded to the Honorable James E. Murray with a request that it be incorporated in the Record of Hearings of the Committee on Education and Labor, and that a second copy be sent to the Honorable Robert M. La Follette, senior senator from Wisconsin and member of that Committee, and be it further

Resolved, That the Wisconsin delegates representing this State Society in the American Medical Association be instructed to introduce a resolution of similar intent and wording at the July 1946 session of its House of Delegates.

Four members of the committee to report the SMS prepaid medical plan: top, Drs. Gunnar Gundersen, W. C. Stewart; bottom row, L. V. Littig, C. O. Vingom.

Dr. Sargent Represents SMS at Hearing on Wagner-Murray-Dingell Bill in Washington

Speech Presented Before the Senate Committee on Education and Labor

Representing the State Medical Society of Wisconsin, Dr. James C. Sargent of Milwaukee, appeared at a hearing on the Wagner–Murray–Dingell Bill before the Senate Committee on Education and Labor, June 21, in Washington, D. C.

The doctor was one of three men selected to represent the society in opposition to the bill, but due to time limitations, there was opportunity for only one doctor to speak.

Doctor Sargent's address follows:

June 21, 1946

Honorable Chairman and Gentlemen of the Senate Committee on Education and Labor:

I am James C. Sargent, a practicing physician in Milwaukee; past-president of the State Medical Society of Wisconsin; and, for nine years, one of the three appointed to represent it in the House of Delegates of the American Medical Association. With Drs. William D. Stovall and H. K. Tenney of Madison, I have been delegated to bring to you the considered judgment of the 2,700 physicians composing the membership of our State Medical Society concerning Senate bill 1606. To conserve important time of this committee I alone am in appearance and I shall take but a moment to elaborate upon our joint statement.

A mass of testimony already has been presented by those representing the profession, pointing out in detail the many seriously objectionable features of bill S. 1606. They are the same objections that the profession, with impressive unanimity, has held against the predecessors of this bill. The same objections will continue to be held against other similar efforts at the regimentation of care of the sick here in America so long as an alert, informed, and deeply concerned medical profession is allowed to survive and remain articulate.

Except as you may request it, I shall not burden you and the record too much by reiterating these many objections in detail. Suffice it to say that the doctors of this great land—they who have spent long years in studious preparation and then have devoted their lives to the prevention of disease and the amelioration of human suffering—they who know what people want and need when sick—these doctors of America have long been familiar with the withering blight that inevitably has settled upon medicine, elsewhere throughout the world and here in America too, when governmental bureaucracy took a third hand in the care of the sick. And in this connection, the physicians of Wisconsin, in common with their colleagues throughout the country, wish to stress the grave danger that lies in this and similar efforts at revolutionary change in long-established medical practice, inspired, as they all have been, by a small but well organized and very vociferous group of social planners who are guided in their notions neither by the background of personal contact with the sick, nor by a proper regard for the clear record of past experience in the thing they propose.

I am detailed to appear before you gentlemen not only to record the considered opposition of the physicians of Wisconsin to this bill as written, but to any modification of it that this committee might consider which persists in the effort to set up a federal bureaucracy to program and supervise the care of the sick in America. Confronted with a powerful lobby in our State Legislature threatening passage of a similar bill to socialize medicine at state level, the physicians of Wisconsin long ago familiarized themselves with the record of sickness care under governmental administration. Nearly ten years ago, they sent the then Executive Secretary of our State Society, Mr. J. G. Crownhart, on a protracted tour of the principle countries of Europe to learn the truth about their experience in governmental medicine. His book, "Sickness Insurance in Europe," has been quoted in testimony already before you. I have a copy which I should like to leave with the committee today. From that careful study, and from the long and unsavory record of sickness care in this country supplied through taxation, governed by bu-

(Continued on page 7, column 1)

J. C. Sargent

"WISCONSIN PLAN"

Because TIME insists on offering only top-flight protection, we unhesitantly offer the "WISCONSIN PLAN."

Its coverage is superior, and those who afford themselves of this insurance have the best hospital and surgical plan on the market today.

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213 W. Wisconsin Ave.
Milwaukee 3, Wis.

DOCTOR WEST ELECTED NEW A.M.A. PRESIDENT

San Francisco, Cal., July 4—Dr. Olin R. West of Chicago, today was elected president-elect of the American Medical Association at the 95th national convention of the organization, held in San Francisco, July 1 to 5.

OLIN WEST

In his acceptance speech, Doctor West, who for twenty-four years was secretary and general manager of the A.M.A., until his resignation April 1, urged the members to battle regimentation so that the medical profession may emerge "untrammeled and be able to stave off efforts to regiment and undermine its services."

Other elections included: Dr. Edward L. Bortz, Philadelphia, vice-president; Major General George F. Lull, Chicago, former army deputy surgeon general, reelected secretary and general manager; Dr. Josiah J. Moore, Chicago, chosen to succeed himself as treasurer; and Dr. F. F. Borzell, Philadelphia, reelected speaker of the House of Delegates, policy making body of the association.

Officers Named For New Insurance Company

Resigning as executive director of the "Plan for Hospital Care," a Chicago Blue Cross organization, John Mannix has become president of the John Marshall Insurance Company of Chicago. The new company will write group accident and health and hospitalization insurance. Mr. Marion Burks, the vice-president and general counsel of the company, was formerly assistant director of the Illinois Insurance Department.

State Board of Health Reports Developments in Hospital Survey

Madison, Wis., July 3—Representatives of the Board of Health are making visits to all hospitals and related institutions for the purpose of examining, reviewing and, where many changes are not involved, collecting the "Hospital Schedules of Information" compiled for the state-wide hospital survey, the Board of Health announced today.

Vincent F. Otis, director of the Hospital Survey, visited approximately 125 institutions before June 30, and is scheduled to make the remaining visits by August 15. State personnel of the Board of Health, located in the nine district health offices throughout the state, are giving material assistance in collecting the short form "Hospital Schedules of Information," sent to nursing, convalescent, maternity homes, and rest homes for the chronically ill.

Deadline Set for Survey Reports

It is estimated that all of the survey reports will be in Madison by August 31, as this date is the deadline for submitting the completed reports. The following time table has been set for the completion of the entire state-wide survey:

August 31—Deadline set for collection of all "Hospital Schedules of Information."

September—Madison office audit of all survey schedules for accuracy and completeness, prior to submitting the schedules for tabulation of information.

October—Completion of coding and tabulation of information.

November—Collection of population, social-economic and vital statistics factors affecting the use and location of hospitals.

December—Consolidation and preparation of all survey material for review and study of the Board of Health and its State Hospital Advisory Committee. Also, consideration to be given any needed state legislation to carry out an over-all state plan for the construction of hospital and health center facilities.

First Complete Inventory of Existing Hospital Facilities

When the collection of all survey reports is completed, Wisconsin will have for the first time a complete inventory of all hospitals and related institutions rendering bedside care to the mentally and physically ill. From this fundamental and basic information will be made known not only the number of institutions, or the total beds available, but also the utilization and adequacy of such existing facilities. Despite the fact that most hospitals are known to be overcrowded and have long waiting lists, there are several general hospitals, that actually have a low bed occupancy and are looking for patients. This is not entirely due to lack of professional personnel. Movement of population, and in some instances the attitude of the community toward the local hospital, have been found as the underlying causes. Such factors emphasize the need for careful hospital planning.

Use of Results of Study

The results of the survey will be used first by the Board of Health and its Hospital Advisory Committee, charged with developing or approving plans for hospital expansion. After the state group has completed its work, other individuals, or groups will use the study in evaluating and perhaps modifying the committee's recommendations. If the recommendations involve state legislation, members of the legislature, and especially legislative committees, will use the study. Civic organizations and leaders interested in better health and hospitalization, local communities that want to establish or enlarge local hospitals, and hospital administrators and trustees who desire to base their plans on sound factual data, are most likely to need and use the results of the survey. The data of the study will be used in justifying recommendations for or against hospital developments in specific communities.

INTERSTATE POSTGRADUATE MEDICAL ASSOCIATION PLANS 1947 ASSEMBLY

Planning in advance, the Interstate Postgraduate Medical Association of North America has scheduled its 1947 assembly to be held at the Public Auditorium in St. Louis, Missouri, Monday through Friday, October 13 to 17, 1947.

ANNUAL MEETING *News*

105th ANNUAL MEETING
MILWAUKEE, OCTOBER 7-8-9
STATE MEDICAL SOCIETY of Wisconsin

Milwaukee, Oct. 7–8–9

■ **COMPLETE PROGRAM READY FOR AUGUST JOURNAL:** The entire scientific program will be printed in the August Journal. Be sure you see this important issue, so that you can plan your schedule well in advance of the meeting and notify your patients that you will be in Milwaukee on October 7–8–9.

* * *

■ **MEDICAL ASPECTS OF ATOMIC BOMBING:** The closing session of the Annual Meeting on October 9 will feature an illustrated paper on "The Results of Atomic Bombing", by Ashley W. Oughterson, M. D., Medical Director of the American Cancer Society.

Another "war paper" will be given by Dr. H. W. Christensen, Wausau, who will discuss "Burns in Naval Personnel at Okinawa," on Wednesday afternoon.

* * *

■ **MEDICAL MOTION PICTURE THEATRE TO REPEAT:** During the general sessions medical motion pictures will be shown in an adjoining room. The selection of motion pictures is being made by Dr. H. Kent Tenney, Madison, and will be announced in the August Journal.

* * *

■ **DR. OLSON ARRANGING FOR OB DEMONSTRATIONS:** Dr. Henry J. Olson, Milwaukee, is making arrangements for obstetric manikin demonstrations, which will be held each of the three days of the Annual Meeting. In each instance demonstrations will be held during the noon hour, directly following luncheon in the Pere Marquette Room of the Hotel Schroeder, and a "repeat demonstration" will be conducted in the same room between 4:30–5:30 p. m. to accommodate those who were unable to attend the demonstration given at noon.

Dr. Jack Greenhill, Chicago, will serve as demonstrator on Tuesday, October 8, directly following his appearance at the Obstetrics and Gynecology Section meeting, presented under the direction of Dr. Benjamin Urdan, Milwaukee.

Full information on all demonstrations will be carried in the September Journal.

Marquette University Receives Infantile Foundation Grant

New York, June 3—A $5,000 grant to Marquette University School of Medicine, Milwaukee, Wisconsin, for continuation of a study of the effects of poliomyelitis on motor nerve ends and muscle has been approved by the National Foundation for Infantile Paralysis, it was announced jointly today by Foundation President Basil O'Connor and the Rev. Peter A. Brooks, president of the university.

The grant is one of 29 totaling $1,527,700 recently approved by the Foundation, and brings to $11,071,962.34 the total appropriated for research and education in the field of poliomyelitis since founding of the organization by the late Franklin D. Roosevelt in 1938. Polio research and education—like the actual treatment of polio patients—are supported by the March of Dimes.

EBEN J. CAREY

The Marquette University research project will be supervised by Dr. Eben J. Carey, dean of medicine and professor of anatomy. The work will be devoted to a study of the true structure of muscle and neuromuscular apparatus — as yet unknown — in connection with the effects of poliomyelitis.

The $5,000 grant to Marquette University School of Medicine brings to $14,500 the total given that institution for research by the National Foundation.

Altmeyer Testimony on S. 1606

April 4, 1946 (From Vol. 3 of stenographic transcript of Hearings, pp. 206, 207.)

Senator Donnell. Do you mind telling us, Mr. Altmeyer, who is the actual author of S. 1606, I mean to say who actually prepared it, if you know?

Mr. Altmeyer. I think it is a product of many minds that were put to work at the request of the authors of the bill.

Senator Donnell. Was Mr. Falks, Isadore Falks, one of the gentlemen who participated in it?

Mr. Altmeyer. Yes, sir, he is director of our bureau of research and statistics.

Senator Donnell. Did he do the bulk of the work in the preparation of S. 1606?

Mr. Altmeyer. I would not say he did the bulk of the work, he did a major or considerable part of it in cooperation with the United States Public Health Service.

PANELS TO BE ISSUED LATTER PART OF JULY

Madison—More than 50,000 employers in Wisconsin will receive copies of the new 1946–47 Workmen's Compensation Panels by August 1, if the present schedule of printing can be maintained.

"Distribution of the 1946–47 Panels has been delayed somewhat by printing schedules," explained Dr. Russell M. Kurten, Racine, chairman of the Conference Committee on Open Panels. "We had hoped to have all panels in the mail by July 15, but scarcity of suitable printing stock and prior printing commitments at the Democrat Printing Company have delayed our distribution. Every effort possible is being made to include all new members of the state and county societies, so that the panels distributed can be used until 1948."

Final Check Made

A final check of all members not filing their applications was made shortly before July 1, and it is expected that all panels will be in the mail by the close of the current month.

Camp American Legion Reopened, For Veterans

Epileptic Rehabilitation Work Coordinated at Milwaukee Meetings

Meeting at the City Club in Milwaukee June 25, at the request of the Rehabilitation Division of the Wisconsin State Board of Vocational and Adult Education, two members of the Division, a representative of the Wisconsin Association for the Disabled, Dr. C. K. Himmelsbach of the U. S. Public Health Service, and Milwaukee physicians, Dr. Edward Schwade, Dr. Valorus Lange, and Doctor Peterman, discussed the problem of epileptics and formulated plans for coordination of the work of rehabilitation of those afflicted with the disease.

A second meeting, held June 26, at the Goodwill Industries, Milwaukee, was devoted to a discussion of difficulties concerning placement of epileptics in industry following the establishment of seizure control. This gathering was attended by representatives of the U.S.E.S., Jewish Vocational Service, Milwaukee County Council of Social Agencies, Doctor Schwade, Doctor Himmelsbach, and members of the Rehabilitation Division.

"Epilepsy is quite a problem here in Wisconsin," declared Mr. A. E. Towne of Madison, who with Mr. J. H. Brown represented the Rehabilitation Division at the meetings. "The Department of Public Instruction has record of approximately 1,500 children of elementary and secondary school age afflicted with epilepsy," he continued, "and there are about 250 children excluded from school attendance in the state because of the disease. These are only the known cases, there may be others not recorded."

"With the use of the new diagnostic measures developed and the substantial advances made in controlling seizures, it is estimated that about 75 per cent of the epileptics, after receiving the benefit of complete evaluation and study, can be controlled to the point where they are employable," Mr. Towne reported.

Evaluation Procedures

He stated that the 8 procedures used in the evaluation of epileptics in rehabilitation work are: 1) general medical examination, 2) psychometric evaluation, 3) psychiatric and neurological evaluation, 4) evaluation by an internist, 5) medical social investigation, 6) vocational diagnosis, 7) vocational training or placement, and 8) the follow-up.

Camp American Legion, Lake Tomahawk, Wisconsin, owned and operated by the American Legion, Department of Wisconsin, opened for another season May 25.

Established in 1925 to rehabilitate veterans with World War disabilities to enable them to return to their normal life and occupations, it still functions to serve any veteran who can benefit physically by life in the north woods.

Veterans of World Wars I and II, both men and women, who are in need of recreation and rest to recuperate from disability or operations are eligible to attend the camp. For the protection of the camp and the patients certain types of cases are not excepted. These include: active tuberculosis, mental cases, alcoholics, contagious diseases, and any residual disease due to misconduct. Veterans needing hospital care are not eligible for attendance.

The camp is equipped and staffed to care for certain types of disabilities. A nurse is on duty at all times and a physician is at the camp one day a week and always on call for special care or emergencies.

Camp Provides the "4–R's"

Camp American Legion, with facilities to accomplish its rules of the "4–R's"—recuperation, rehabilitation, rest, and restoration, had an endowment fund of $100,000 when it was established 21 years ago. Since the beginning of World War II, an additional endowment fund of $250,000 has been raised to permit the camp to continue its work of benefiting the veterans at no cost to the veterans themselves. There is no charge for patients at the camp for board or care, and transportation cost is furnished if not supplied by another agency.

Patients at the camp, that occupies 17 acres in the midst of the 2,700 acre American Legion Wild Life Refuge, are assigned to cabins, are provided meals (if a veteran is on a special diet, such diet is followed), and use of recreational facilities, in charge of the recreational director, for fishing, tennis, gardening, crafts, swimming, and reading and lounging in the Main Lodge.

The minimum period authorized for a veteran to stay at the camp is 10 days, the maximum, 30 days. Further stay may be authorized if the camp physician recommends it and it is considered beneficial.

Application Procedure for Attendance

Physicians desiring information to recommend veterans for recuperation at the camp, and veterans seeking admittance can secure application blanks at American Legion Posts or through mailed request to Mr. J. F. Burns, Department Service Officer, The American Legion, Wood, Wisconsin. Forms received are to be filled out and returned to a Post Officer for approval by him and by the Department Service Officer. No veteran can be accepted at the camp until properly authorized by the Department Service Officer.

DR. H. R. HENNESSY APPOINTED ASSISTANT SECRETARY, COUNCIL ON INDUSTRIAL HEALTH

Chicago—Dr. Harold R. Hennessy, formerly of Los Angeles, has recently been appointed assistant secretary of the Council on Industrial Health, American Medical Association, and is now on duty with the headquarters staff in Chicago.

He will also act as executive officer for the Council's Committee on Professional Relations of which Dr. A. J. Lanza of New York, is chairman.

A 1930 graduate of the University of Minnesota Medical School, the doctor attended the University of California, 1938–1939.

During the past five and one-half years, Doctor Hennessy has been in the armed forces, serving with the Army's public health program. A lieutenant colonel in the Medical Corps, he was chief of Industrial Medicine, Office of the Surgeon, Headquarters Ninth Service Command before he was assigned two years of overseas duty in England, France, Belgium, and Germany, with the military government public health program. For meritorious service in connection with military operations in April and May, 1945, he was awarded the Bronze Star Medal.

DR. SARGENT'S SPEECH—

(Continued from page 3)

reaucracy, and carried out by doctors under fee schedule, panel, or contract, we in Wisconsin have come to know what happens to the sick man when a third party is thus interposed between him and his doctor.

Title II is the meat of this proposed legislation. May I enumerate four of the most objectionable features relating to this title.

First: Title II does, in fact, interpose a third party between the patient and his doctor. An enormous federal bureaucracy composed of local, state, and national administrative units, headed up by the Surgeon General of the United States Public Health Service, by the provisions of the bill, must bargain for the services which the sick man is to receive, and in turn must determine the limitations under which the sick are to receive their care.

Second: Bill S. 1606 denies a sick man free choice of his physician. Section 205, paragraph (j), details the procedure whereby physicians under the system are to be limited in the number of people they serve. Beyond that limit, all patients must accept a doctor other than their choice, or forego the benefits promised them. Moreover, the physicians of America have not been brought up to the type of practice contemplated in this proposed legislation, and so long as any opportunity for private medical practice remains, those physicians whom sick people now pick most often as their choice, will succeed in remaining out of the system. How, then, could there be free choice of physicians except the sick man himself go outside the system and pay a second time for the medical care that he wants?

Third: Without prejudice to the professional conviction that any medical service supplied under bureaucratic management cannot possibly compare with the time-honored system of private medical practice either in cost or quality of service, I would point to the fact that Title II of this bill as written does not provide anything like complete and adequate care of the sick man. Indeed, it fails him when he is in greatest need. Section 210 is devoted to limitations of benefits and its paragraph (c) stipulates that the maximum number of days of hospitalization shall be limited to sixty—unless funds happen to permit extension to 120 days. The great mass of people, particularly with the aid of presently available voluntary hospital and sickness insurance, can well afford the ordinary costs of acute illness. What they cannot bear are the catastrophic, long-term illnesses. The man whose daughter has a broken back, whose wife has a cancer, or who himself suffers from disabling arthritis, kidney or heart disease is the man who is in genuine need of help.

In like manner, this bill takes a most casual interest in the man sick to the point where he is in need of the costly services of a highly qualified specialist. Section 205, paragraph (d), specifies that the determination of the need for these superior services shall rest solely with the general practitioner working under the system, and an administrative officer of the system. And if long past experience with bureaucratic medicine has any lesson at all, it is, as Mr. Crownhart points out, "the effort of government is always directed toward confining the service so that its cost may fall within the limits of the money that is raised." Gentlemen, under this bill, not only are necessary services sharply limited, but the limitations become

(Continued on page 8, column 1)

Reprint From The Milwaukee Journal

The Reference Committee on Resolutions at the special session, June 22, in Madison, had as members: from left, Drs. L. O. Simensted, Osceola; J. S. Supernaw, Madison; K. H. Doege, Marshfield; E. D. Sorenson, Elkhorn; and R. P. Montgomery, Milwaukee.

DR. L. R. COLE RETURNS TO UNIVERSITY STAFF

Madison, Wis., July 8—After a year's leave of absence, during which he was making some special studies, Dr. Llewellyn R. Cole has returned to the University of Wisconsin to continue as professor of clinical medicine, and to hold the new position of coordinator of graduate medical education.

LLEWELLYN R. COLE

Doctor Cole's primary responsibility will be the correlation and organization of graduate instruction, including refresher courses such as are now offered and others. His duties will embrace various phases of public health information, and will permit him to continue as director of the State Medical Society's radio series, The March of Medicine.

These radio programs have been broadcast each week for over a year on twelve Wisconsin stations and for lesser periods on two others. The present schedule appears on page 696 of this issue of the Journal.

As a member of the Society's Committee on Health and Public Instruction, Doctor Cole also writes a health column under the title, "Wisconsin Doctors Say . . ." for the Wisconsin Agriculturist and Farmer which has a circulation of about 185,000, practically all of which is rural.

DR. SARGENT'S SPEECH—

(Continued from page 7)

operative just when a sick man has reached the point where he is genuinely in need of assistance.

And finally: Nothing in this bill indicates the likely costs to be involved in the supply of "Prepaid Personal Health Service Benefits." Even in this era of profligate governmental spending, the billions that must be involved should in all fairness be made known to the two parties who will have to carry the costs—the insured man and the tax payer. And, since the total budget must set a ceiling on the amount and quality of sickness care that such a system can afford, the sick man who is to need the "Health Service Benefits" has a clear right to know what monetary guarantee there will be back of him; what price and therefore what kind of medical care he is to be furnished when he is in need of it.

Gentlemen, bill S. 1606 is a bill proposing State Medicine, the protestations of its proponent to the contrary not withstanding. It is a bill calling for Socialized Medicine in America. It will, if enacted, raise the costs of the care of the sick enormously and at the same time cheapen its quality. And worst of all, it proposes a radical departure from the good old doctrine of individual responsibility and free enterprise that has made America and American Medicine so great.

RETURN CHILD HEALTH REPORTS, PHYSICIANS URGED

Madison, Wis., July 9—To keep Wisconsin doctors posted on the progress of the Wisconsin Child Health Study, Mr. Thomas Doran, executive secretary of the American Academy of Pediatrics, Survey of Child Health Services, reports that 1,901 questionnaires have been sent to the physicians in the state. None have been mailed to the physicians in Milwaukee County as yet, but they will receive the questionnaires in the near future.

"Up to this time, 891 questionnaires have been returned," Mr. Doran announced, "and more are coming in every day. To the physicians who did not return the one page report, one more questionnaire will be sent."

"This is more than a study of the practice of pediatricians," Mr. Doran continued, "total information is needed on the training, type of practice, and extent of service to *all* patients of all physicians, even those who never treat children."

Bills are before Congress at present, proposing legislation for Maternal and Child Health. If the Academy is to be in a position to make recommendations on the basis of factual data, the study is essential now.

"The final report of this study will be written on a county basis. If the information from the physicians is *not* received a true report on what medical care is being extended cannot be compiled. Some counties will appear to be forgotten areas in the medical field. This should not happen. No adequate well-grounded plan can be formulated without basic information," Mr. Doran declared.

He concluded, saying, "We hope in the next issue of *The Wisconsin Medical Journal* we can report at least 75 per cent return of questionnaires."

EMIC PROGRAM TO CONTINUE IN EFFECT

Madison, Wis., July 8 — The Emergency Maternity and Infant Care program continues in effect until six months after Congress declares the end of the war, according to a report from the Bureau of Maternal and Child Health, State Board of Health. No such declaration by Congress has been made as yet.

Individuals eligible under the program are:

1. Any woman whose husband (regardless of subsequent promotion or discharge) was in one of the four lowest pay grades of the armed forces *at any time during her pregnancy.*

2. Any sick infant under one year of age whose father was in one of the four lowest pay grades (regardless of subsequent promotion or discharge) *at any time during its prenatal period or first year of life.* Well-baby supervision and immunizations and vaccinations are not included under the plan.

Physicians returning from military service or beginning practice in the state should write to the *Bureau of Maternal and Child Health, Wisconsin State Board of Health, Madison 2, Wisconsin,* for information and application forms.

Physicians ordinarily called as consultants are urged to file a form indicating their training and experience with the MCH Bureau. This procedure is necessary to establish eligibility for payment under the requirements of the EMIC program.

The
MEDICAL FORUM

The Wisconsin Medical Journal August, 1946

AMA CHALLENGES PEPPER'S SUBCOMMITTEE REPORT

Repair of Respirators Proceeds in State

Lake Mills, Wis., Aug. 1—Iron lung respirators throughout Wisconsin are being inspected and repaired as part of a state-wide poliomyelitis preparedness campaign, it was announced here today by Mr. Palmer F. Daugs, state representative of the National Foundation for Infantile Paralysis.

Mr. Daugs reported that the inspection was suggested by Dr. Carl N. Neupert, state health officer, and that the program had already been completed in Douglas, Marathon, Waushara, La Crosse, Washington, Sheboygan, Manitowoc, Winnebago, Outagamie, Fond du Lac, Marinette and Brown counties.

The program is being arranged by Mr. Daugs, while costs are defrayed by National Foundation chapters serving the various areas involved. Doctor Neupert said the 33 cabinet-type respirators scattered in hospitals throughout the state were adequate to meet ordinary needs.

The inspection-maintenance project would provide respirators in "A-1 condition for instant use in the event of an emergency," Mr. Daugs explained, adding that the

(Continued on page 7, column 3)

DOCTOR COOPER IS VD SPECIAL CONSULTANT TO ST. BD. OF HEALTH

Dr. Garrett A. Cooper of Madison, dermatologist, and director of the State Venereal Disease Clinic since 1942, has recently been selected to also act as special consultant in venereal disease to the State Board of Health.

In this capacity, Doctor Cooper handles technical requests of special cases referred to him by the State Board of Health. He advises the physicians requesting information in the management of their cases.

SEN. PEPPER'S REPORT OF SUBCOMMITTEE AS GIVEN TO PAPERS

Appearing July 22, in *The Evening Star*, Washington, D. C. newspaper, was the following story, similar to those printed in newspapers throughout the country, giving a report on the Senate Subcommittee on Health and Education, released by Senator Pepper, concerning the national health insurance bill. The article in part follows:

"A Senate Subcommittee on Health and Education today issued a report urging a national health program to be carried out through compulsory health insurance to provide complete medical care at reasonable cost.

The report of the subcommittee, which is headed by Senator Pepper, Democrat, of Florida, said:

"'. . . To cover every one, the adverse as well as the good risks, the young and the old, the sick and the well, the rural and the city dwellers, the low and the high income groups, the poor and the rich areas, all this takes a mechanism as representative and all-inclusive as a national health program, built around a system of prepaid medical care.

"'It must be financed by required contributions to the social security fund and by payments from general tax revenues. Such a program will . . . make possible the achievement in the forseeable future of our goal of high quality health care for all.'

"The report represents substantial approval of President Truman's health measure of November, 1945, and of the Wagner–Murray–Dingell health bill, but neither is indorsed specifically. The Wagner–Murray–Dingell bill is based on the President's proposal but makes no provision as to the

(Continued on page 4, column 3)

AMA JOURNAL TERMS REPORT RELEASED TO PAPERS "IMPROPER"

Commenting editorially on a wide spread newspaper report that the Subcommittee of the Committee on Education and Labor of the United States Senate issued a statement favoring compulsory sickness insurance, *The Journal of the American Medical Association*, in the August 3 issue, states as follows:

"Many doctors throughout the nation were startled by a widely circulated newspaper report to the effect that a subcommittee of the Committee on Education and Labor of the United States Senate had issued a report favoring compulsory sickness insurance. Accompanying the report when issued was a newspaper release of considerable length which indicated that it was the belief of this subcommittee that private medical insurance plans have failed; also that the report represented 'substantial approval of President Truman's health message and the Wagner–Murray–Dingell health bill by a bipartisan group of Senators; but neither are specifically endorsed.' The report was signed by Senators Pepper, Florida; Aiken, Vermont; Thomas, Utah, and Murray, Montana. It was stated that Senators Taft, Ohio, and Smith, New Jersey, dissented from some of the findings and conclusions of the report and that Senators Hill, Alabama, Tunnell, Delaware, and Morse, Oregon, 'have not completed their study of the subject of this report.' On July 23 Senator Donnell, Missouri, took Senator Pepper severely to task before the Senate, charging that the subcommittee had no right to issue such a report to the press before it had been submitted to the entire committee. He charged that the press release contained misstatements of

(Continued on page 4, column 1)

LEFT UNHAMPERED, MDs WILL DEVELOP GOOD MEDICAL CARE PLANS, PROFESSOR PREDICTS

Prediction Based on Survey of Six Voluntary Medical Care Plans

Chicago, Ill., July 19—If left unhampered, the American medical profession will develop sound, practical methods for providing medical care to all the people at low cost, without wasteful government interference, it was predicted today by Herbert Simpson, professor emeritis of public finance at Northwestern University.

The process is necessarily slow, Professor Simpson said, and there has been a "normal" lag between recognition of the need and establishment of the means to meet it, but much has already been achieved despite the need for "bringing about changes in point of view that are little short of revolutionary."

Professor Simpson, acting on behalf of the National Physicians Committee for the Extension of Medical Service, has just completed a study of voluntary medical care plans operated by the medical profession, in California, Oregon, Washington, Michigan, New Jersey, and Massachusetts, and compiled a printed report, entitled *Health Protection.*

Since the medical profession, he found, began experimenting with medical care plans in the Pacific Northwest in the early 1900's, the development of such plans has been pressed "gradually, sometimes cautiously," by the far sighted among leaders of the profession. The depression of the 1930's accelerated the process, but the war slowed it down. More recently, it has resumed its advance, until a Social Security Board study of 1945, he cited, found 229 plans in operation, large and small.

"There is always a lag between scientific discovery and the practical adjustments that follow," Professor Simpson wrote. "So there has been a lag between medical discovery and the revolutionary adjustments in medical organization and practice that will follow. The present movement toward prepayment medical and hospital service plans represents one of these adjustments."

"The development of these medical service plans," observes Professor Simpson, "may prove to be effective prophylactic against the extension of political activity and governmental authority in this field."

The six plans studied by Professor Simpson represent a cross-section of the more common types of medical care plans now operating. He commented that the great variety in types of organization, service, and methods of operation shows the plans are flexible and that they can be adapted to the conditions of the areas in which they are in force.

"This fact would appear to carry assurance that, in general, the prepayment medical service plan affords a mechanism of seemingly unlimited capacity to meet the varying needs of the people of the United States. Needless to say, it affords a sharp contrast between the flexibility of privately organized services and the rigidity of a politically regimented medical service."

Essential to a medical service plan, Professor Simpson decided, are (1) the wholehearted cooperation of the physicians of the area involved; (2) a sound financial setup; (3) a capable administrative organization and staff; (4) effective internal policing to prevent any abuses on the part of doctors; (5) cordial public relations, which must include liberal interpretation of contract provisions in favor of the patients.

The results of the development of such sound medical service plans based on experience can be predicted, Professor Simpson continued. Wider distribution of medical service, more stable incomes for doctors and a higher level of national health will certainly follow, he wrote.

Fred L. Holmes Dies During Address at Waukau Centennial

Noted Author, Lawyer, and Historian Collapses on Platform

While delivering a centennial address July 27, in Waukau, the Winnebago county village where he was born, Fred L. Holmes, 63, Madison attorney, journalist, historian, and nationally-known author, collapsed and died on the platform.

For three years after his graduation from the University of Wisconsin in 1906, Mr. Holmes was political reporter and city editor of The Wisconsin State Journal, Madison. He then became manager of La Follette's Magazine, and established the Holmes News Service, supplying news to papers in the northwest for almost twenty years.

After serving for two terms as a Republican in the legislature, Mr. Holmes resumed work on La Follette's Magazine. He left that position in 1929. Mr. Holmes was national publicity director of the La Follette–Wheeler presidential campaign in 1924.

Although he did not have a law degree, by ranking one of the highest in examinations, Mr. Holmes was admitted to the Wisconsin Bar Association in 1927.

Mr. Holmes was closely identified with various health activities in

(Continued on page 5, column 2)

Two members of committee appointed at House of Delegates meeting to report the SMS medical plan: Drs. E. M. Dessloch and A. T. Nadeau.

The Medical Society of the State of Pennsylvania presents an interesting analysis on the money available for treatment and research for some of the more prominent causes of illness. It announces that for each of the 175,000 cases of infantile paralysis $94 is available, while for 680,000 cases of tuberculosis only $22 is available for each case.

There are about 500,000 cases of cancer each year for each of which $8 is available, but for heart disease which causes 426,000 deaths a year, there is only 3 cents a case available.

* * *

An interesting commentary on administrative government arises out of the current situation involving the Wagner–Murray–Dingell bill. According to Marjorie Shearon who is the research analyst for the Conference of the Minority of the U. S. Senate, the proposed Federal Security budget for 1947 includes an item of $90,000 for Public Health Methods, the division of the Public Health Service working on sickness insurance in collaboration with Isadore Falk of the Social Security Board.

It is funds like these which apparently pay the expenses of Doctor Perrott and Doctor Mountin on their present three months' European tour of studying sickness insurance systems.

And, while we are on this point, the behind-the-scenes organizer of hearings on the Wagner–Murray–Dingell bill is a member of the staff of the Reconstruction Finance Corporation which has granted a leave of absence to this particular individual. It is understood that Captain Miller, head of the Federal Security Agency, has asked the Reconstruction Finance Corporation to extend the leave for a further period.

Incidentally, the Rosenwald Fund is back in the picture again, having given $165,000 to Michael Davis' Committee on Research in Medical Economics, an organization which was quoted by Senator Wagner as composed of health experts. Among these experts are not only seven federal employees but Doctor Boas, chairman of Physicians Forum; Mr. Alexander, vice-president of the Rosenwald Fund; Michael Davis; and J. R. Walsh, research director of the CIO.

* * *

It has been reported in the Forum that California has adopted a cash sickness benefit plan requiring a benefit of $80 monthly, and it is apparently the feeling in California that most group coverage provided by private carriers for covered employees will be furnished by compensation carriers, and that it is unlikely that compulsory plans will cut much ice in the picture.

* * *

The Wisconsin Anti-Tuberculosis Association has formed "impressions" as to the effect of the free care program for Wisconsin's tuberculous, frankly admitting that a year's experience is insufficient for a detailed sociologic study. The association nevertheless believes that the free care law has relieved patients of financial anxiety, and that the length of time between diagnosis and hospitalization has been shortened.

The association concludes that out-of-state patients having the requisite residency in Wisconsin have been able to return to be near their families, thus making better adjustment to the program of care.

In addition, says the association, the problem of collection from the private pay patient has been eliminated and the volume of discharges against medical advice has declined markedly.

* * *

There is considerable interest in the attitude of the osteopaths with respect to compulsory health insurance. A. W. Bailey, osteopath, chairman of the American Osteopathic Association's Committee on Health Insurance, believes that the Wagner–Murray–Dingell bill should be amended so as to include osteopaths.

He stated that he was quite certain in his mind that if the bill were amended, as he suggested, his organization would be found in support of the proposal.

Another who testified on the Wagner–Murray–Dingell bill was Andrew T. Court of the Labor Economic Section of General Mo-

(Continued on page 6, column 1)

COUNTY SOC. REPORTS DOCTORS' FEES RAISED

The Pierce and St. Croix County Medical Society inserted a paid advertisement in the newspapers of the two counties July 4, announcing a raise in fees for medical services offered by the members, that went into effect July 1.

The increase in costs, particularly those of office supplies, has made the raise in minimum fees for office visits, house calls, and obstetrical cases a necessary measure. The minimum charges stand at present as: $2 for office visits; $3 for house calls; and $5 for night house calls, the society reports. All obstetrical cases not arranged for previously, are $50, including prenatal visits and one six week post-natal examination for mother and child.

RUSH

Your patient is often our policyholder. When he presents you with one of our claim blanks, you will be helping him tremendously by completing it immediately.

Our claim blanks are intended to be simple, because your answers to our questions are important to prompt payment of claims. Please, doctor, don't delay those claim reports, and thanks.

(If you have any ideas as to how our claim reports could be made more clear—we're listening!)

The Time

Insurance Company

213 W. Wisconsin Ave.

Milwaukee 3, Wis.

Bureau For Handicapped Children Schedules Orthopedic Field Clinics Throughout State

Madison—Orthopedic field clinics, conducted by the State Department of Public Instruction, Bureau for Handicapped Children, are being held at cities within the state this month and on through November. Frank V. Powell, director of the Bureau, reports.

The clinics, two of which have already been held, in Lancaster, July 2, and in Ashland, August 9, are for persons under 21, who come within the state's definition of a crippled child. The orthopedic field clinics schedule is as follows:

Wausau	August 30
Kenosha	September 24 & 25
Racine	September 27
Superior	October 4
Green Bay	October 17 & 18
Eau Claire	October 24 & 25
Sheboygan	November 1
Appleton	November 15
La Crosse	November 22

Mr. Powell explains that children should be referred to the clinics by family physicians, but when that is not feasible, arrangements can be made by writing to the Bureau for Handicapped Children, 146 N., Capitol, Madison 2. Forms for the purpose of referral should be requested from the Bureau in advance of the clinic date, as the personnel arrangement at the clinics depends upon the number of people to be examined.

Appointments Made in Advance

Families who return the signed referral forms are notified of the appointment hour several days before the clinics. Physicians and parents are permitted to attend the clinics with the children.

AMA JOURNAL—

(Continued from page 1)

fact and that the entire procedure was improper. On July 24 Senator Pepper replied, claiming that he had been trying to get action on his report because his committee was to be discharged on August 1. He admitted the misstatements of fact in the press release and he admitted that it was not proper to say 'bipartisan' when only one member of the minority party had given his assent. He admitted that there 'might be some technical delinquencies on the part of himself as chairman' but stated that 'it was not intentional,' and he apologized in the words 'I am exceedingly sorry that inadvertently such a thing may have occurred.' The Senate was so greatly concerned with the extension of price control that the debate was halted. This comment is published to reassure physicians that the Senate Committee on Education and Labor has not acted on the Wagner–Murray–Dingell bill. The release of the report by Senator Pepper together with the press release may well be considered propaganda of the same type as has regularly characterized the actions of Senators Pepper and Murray."

MEDICAL VETERANS CLUB ORGANIZED IN MILWAUKEE COUNTY

The Medical Veterans of World War I and II of Milwaukee County, a group organized in October, 1945, to provide meetings for the discussion of common problems and social gatherings for medical men with military experience, has elected the following men as officers: Drs. Maurice Hardgrove, president; James A. Sullivan, president-elect; Roland Galasinski, treasurer; and Stanley W. Hollenbeck, secretary.

MAURICE HARDGROVE

All medical officers of World War I and II are eligible to join the group. The members would like to know if medical veterans throughout the state are interested in organizing respective groups or might wish to affiliate with the Milwaukee organization.

One in Ten Madison Veterans Jobless

"One out of every 10 men from Madison who entered service is out of work today," reports Mr. Joseph Roberts, manager of the Madison district office of the United States Employment Services (USES).

"The problem is acute now," he said, "even while the men are receiving their adjusted compensation that cushions their return to civilian life.

"A year from now, when those payments stop coming in the situation is going to be just that much worse, unless we can find jobs for them in the meantime."

PEPPER'S REPORT—

(Continued from page 1)

manner in which the health insurance program would be financed.

"The subcommittee's report is signed by Senator Pepper and Senators Aiken, Republican, of Vermont; Thomas, Democrat, of Utah, and Murray, Democrat, of Montana. Senators Taft, Republican, of Ohio, and Smith, Republican, of New Jersey, dissent from some of the findings and conclusions. It was announced that Senators Hill, Democrat, of Delaware, and Morse, Republican, of Oregon, have not completed their study of the subject of the report.

"Senator Pepper said that the 'false accusations of socialized medicine and restriction of free choice against the President's health program are red herrings' and called for a constructive attitude toward adoption of Mr. Truman's national health plan.

"The report called for immediate action because of the 'urgency of our health needs as shown by selective service and Army data and substantial evidence that we are not the healthiest country in the world.'

"The report called insurance 'the well-tried American way of meeting the hazards of life.' It declared that the plan would represent 'primarily an increase in existing tax-supported health services,' adding that 'no one need be horrified since more than 20 per cent of our medical expenditures are already tax supported.'

"'Free care does not fill the gap,' the report contends, 'because little public money is spent for such care for rural, small-town and urban areas.'"

VA Needs Physicians For Clinical Positions in Sub-Regional Offices

Appointments Open in Six Cities

Milwaukee, Wis., Aug. 2—Physicians are needed by the Department of Medicine and Surgery of the Veterans Administration to meet the expansion of activities to VA sub-regional offices throughout Wisconsin, VA officials announced today.

Salaries for these full-time positions are $4,902, $5,905, $7,102.20, and $8,179.50 per year.

The appointments, not under civil service jurisdiction, are clinical positions concerned with outpatient treatment in the Madison, Wausau, Superior, Eau Claire, Green Bay, and La Crosse subregional offices of the VA.

The final allocation of salary grades will rest with the Professional Standards Board of the VA Branch 7 Office in Chicago. However, letters of inquiry about the positions should be addressed to the Personnel Office, Veterans Administration Regional Office, 342 N. Water St., Milwaukee 2, Wis.

HEALTH OFFICER APPLICANTS OFFERED NEW ALLOWANCE

Physicians being selected as district health officers under the Wisconsin civil service requirements are being offered a training allowance of $360 a month by the State Board of Health for postgraduate training in public health work, according to an announcement from the State Board of Health.

Tuition and travel cost will also be offered to the men who will train for one or two semesters at a university with an accredited course in public health, and then direct activities in public health through the state's district health offices.

Veterans Given Preference

Licensed physicians or those eligible for licensure up to 50 years of age may apply for the training, but veterans and younger men will be given preference.

For details on this new training allowance policy refer to page 765 of this issue of the *Journal.* Those interested in applying for the training should write to the State Board of Health, Madison, Wisconsin.

FRED HOLMES DIES—

(Continued from page 2)

Madison and assisted the State Medical Society in news releases and other matters during a period of many years.

First Book Printed in 1915

As an author, Mr. Holmes gained wide recognition. His first book, "Regulation of Railroads and Public Utilities in Wisconsin," was printed in 1915 and was used for teaching purposes in colleges. At the close of World War I he wrote "Wisconsin's War Record."

As an historian too, Mr. Holmes used a great amount of historical material in his later books. He and his wife, the former Helen Pollock of Madison who died seven years ago, often made trips through the state gathering information for books on Wisconsin's history and residents which became some of his most famous works. They included: "Alluring Wisconsin," "Badger Saints and Sinners," "Abraham Lincoln Traveled This Way," "George Washington Traveled This Way," and "The Voice of Trappist Silence."

In June, 1942, Mr. Holmes was awarded an honorary doctor of laws degree by Marquette University.

Surviving Mr. Holmes are four sisters, a niece, and four nephews.

Belgian Miners' Pension Fund

The Belgian Miners' Pension Fund provides old-age and survivors' pensions; sickness, invalidity, and unemployment benefits; family allowances; and annual vacations, financed from contributions by the workers amounting to 8 per cent of wages (as in other industries), and by employers amounting to 17.5 per cent of pay roll for surface workers and 21.5 per cent of pay roll for underground workers (as contrasted with an employer contribution of 15.5 per cent in other industries), according to the June, 1946, issue of *Labor Review.*

Polio Foundation Names Dr. Hart Van Riper Medical Director

New York, July 1—Former Madison pediatrician, Dr. Hart E. Van Riper, now of Scarsdale, New York, has been appointed medical director of the National Foundation for Infantile Paralysis, the organization's president, Basil O'Connor, announced today.

HART VAN RIPER

Doctor Van Riper, who has served as acting medical director since January, will guide the foundation's program for research, education, and medical care and treatment for infantile paralysis patients throughout the nation.

In private practice as a pediatrician in Madison from 1933 to 1941, Doctor Van Riper also served as medical director of the Wisconsin Life Insurance Company. His wife, the former Mary-Virginia Smith, is from Madison.

Certificate Conferred Upon Green Bay Station

Madison, Wis., July 8—Radio station WTAQ, Green Bay, was awarded a certificate of merit identical to those conferred upon twelve other Wisconsin radio stations last month, for broadcasting each week for a year The March of Medicine as an educational feature.

The March of Medicine appears on the Green Bay station each Friday at 3:45 p. m. The transcribed broadcasts, which are designed for Wisconsin audiences in the interest of health improvement, are approved by the Wisconsin Joint Committee for Better Radio Listening.

CAPITOL VIEWS—

(Continued from page 3)

tors Corporation. Wisconsin physicians will recall that Mr. Court appeared in a general discussion of this subject and allied problems at their annual meeting about three years ago.

Mr. Court quoted from Doctor Sinai's book, "The Way of Health Insurance," to the effect that "It seems to be a safe conclusion that insurance has certainly not reduced the amount of sickness."

Appointments to Medical Advisory Comm. Announced

Madison, Wis., July 1 — Three men and one woman received appointments today as members of the State Medical Advisory Committee to the Wisconsin State Board of Vocational and Adult Education, filling the posts of members whose term has expired, according to a report from the Board.

The new appointee, Miss Janet Jennings, and those re-appointed, Drs. Charles Fidler, J. S. Supernaw, and G. F. Wakefield, will serve until July 1, 1949. The committee in full now consists of the following members:

	Representing
Three year term expires July 1, 1947	
H. M. Coon, M. D.—Wisconsin State General Hospital, Madison 6	Hospital Administration (A. B. Internal Medicine)
H. L Greene, M. D.—1 S. Pinckney St., Madison 3	Orthopedic Surgery
T. J. Howard, M. D.—716 N. 11th St., Milwaukee	Internal Medicine
R. M. Kurten, M. D.—810 Main St., Racine	General Surgery
Three year term expires July 1, 1948	
H. J. Heeb, M. D.—212 W. Wisconsin Ave., Milwaukee 3	Ophthalmology
C. N. Neupert, M. D.—State Board of Health, State Office Bldg., Madison	Public Health (State Health Officer)
H. H. Reese, M. D.—Bradley Memorial Hospital, Madison 6	Psychiatry & Neurology
Miss Marjorie Taylor—750 N. 18th St., Milwaukee 3	Physical Therapy and Occupational Therapy
J. K. Trumbo, M. D.—526 3d St., Milwaukee 3	Otology
Three year term expires July 1, 1949	
Charles Fidler, M. D.—231 W. Wisconsin Ave., Milwaukee	Past president, State Medical Society
Miss Janet Jennings—Sup. of the Bureau of Public Health Nursing, State Board of Health, Madison	State Public Health Nursing
J. S. Supernaw, M. D.—110 E. Main St., Madison 3	General Surgery
G. F. Wakefield, M. D.—West Salem	General Practice
Ex officio:	
A. W. Bryan, M. D.—16 S. Henry St., Madison 3	Med. Administrative Consultant, Rehab. Div.
Mr. C. H. Crownhart—Secretary, State Medical Society, 110 E. Main St., Madison 3	Secretary, State Medical Society
Mr. W. F. Faulkes—Rehabilitation Division, State Board of Vocational and Adult Education, Madison 2	Chief, Vocational Rehabilitation
P. R. Minahan, M. D.—110 N. Washington St., Green Bay	Pres., State Med. Society
Mr. A. E. Towne—Rehabilitation Division, State Board of Vocational and Adult Education, Madison 2	Supervisor, Physical Restoration

Officers:

T. J. Howard, M. D. ---------- Chairman
Mr. C. H. Crownhart ---------- Secretary

INFANTILE FOUNDATION OFFERS ADVICE ON TRANSPORTATION OF POLIO PATIENTS

The transportation to hospitals of acute infantile paralysis cases presents special problems, the National Foundation for Infantile Paralysis reports, and offers the following advice for transportation management.

The patient should not be permitted to sit up in an automobile, but should always be placed in a recumbent position on a rigid frame or mattress. It may be necessary to use boards to keep the body in a straight position. If paralysis involves arms or legs, these should be supported and restrained by the use of pillows, sand bags, or splints. If there is involvement of the legs, these should be held nearly parallel to each other and not be twisted to either side. When there is much spasm in the muscles of the legs it may be necessary to place a small pillow or a rolled towel under the knees to ease the discomfort and to overcome the danger of sudden stretching of muscles in spasm. A similar pad may be needed under the back. The arms should be kept at the side of the body with the elbows slightly bent.

If the patient is suffering from the bulbar type of the disease where breathing is disturbed or where there is inability to swallow, then the patient's body should be tilted so that the head is about four inches lower than the rest of the body. This allows for postural drainage of mucus and saliva and prevents pneumonia due to aspiration of this material. The attendant should be supplied with cotton swabs to help remove mucus from the throat.

These instructions should be given to all ambulance drivers, nurses, parents, and others concerned with transportation of the acute infantile paralysis case.

FRED V. HEIN JOINS AMA AS HEALTH CONSULTANT

Mr. Fred V. Hein has recently resigned as director of health and physical education in the public schools of Oshkosh to accept a position as consultant in health and physical fitness to the Bureau of Health Education of the American Medical Association.

A graduate of Ripon College with the class of 1929, Mr. Hein received his M.S. degree from the University of Wisconsin, and took courses at the Center for Health Education, New York University. At present he is completing work on his Ph.D. degree in Madison and teaching courses in physical education at the University of Wisconsin summer school.

Taught in Kenosha, Berlin, and Oshkosh Schools

Prior to his location in Oshkosh in 1938, Mr. Hein taught physical education and health in the Kenosha and Berlin public schools. During the war he served as director of physical training and taught medical aid courses in the Army Air Corps training program at Oshkosh State Teachers College.

Active in education and health organizations, the new AMA health consultant served as past-president of the Wisconsin Association for Health and Physical Education, and as chairman of several sections of the Midwest Physical Education Society. He is a member of the American Association for Health, Physical Education, and Recreation, the National Education Association, and the American School Health Association.

VA Expands Program, Starts Mental Hygiene Clinics in Regional Offices

Clinics Will Offer Treatment on Out-Patient Status

Washington, D. C., July 31—An expanded program for the thousands of World War II veterans suffering emotional illnesses of service connected origin was authorized today by Veterans Administration.

Under a new directive, deputy administrators of the 13 branch areas have been given permission to establish mental hygiene clinics in any of the agency's 70 regional offices when such additional facilities are rated as "necessary" and the professional staff can be employed within existing personnel ceilings.

The VA directive set the following official policy:

"The need for treatment of the large numbers of veterans discharged from service with mental and nervous illnesses is evident. Experience . . . indicates that the majority of these cases can be treated effectively in a clinic without hospitalization.

"The mental hygiene clinics will render this treatment on an outpatient status and will be responsible for conducting the entire outpatient neuropsychiatric treatment program in the selected regional offices.

"This program will serve to alleviate a minor neuropsychiatric illness, prevent the development of a more serious illness, and consequently reduce the number of veterans requiring hospitalization."

(Continued on page 8, column 3)

RESPIRATORS—

(Continued from page 1)

Foundation's own 25 respirators could be used to supplement hospital lungs if needed.

Mr. Oscar E. Olson, Madison engineer who is inspecting and checking the respirators, is also conducting demonstrations of the equipment for nurses, health officers, county chapter members, and other interested individuals.

Public demonstrations have been held in hospitals in La Crosse, West Bend, Sheboygan, Manitowoc, Fond du Lac, Appleton, Marinette, and Green Bay. Over 140 persons attended the demonstration in the auditorium at St. Agnes Hospital, Fond du Lac.

A National Foundation 1946 publication, "The Use of the Respirator in Poliomyelitis," has been widely distributed to hospitals throughout the state.

Physicians Urged to Promote Participation in Health Course For Children

Radio Course Run Under New Title

Physicians throughout the state can aid in the promotion of better health and sound health practices among children, the Committee on Health and Public Instruction believes, by discussing with school administrators and teachers the participation of the schools in their communities in the health education course, *Fit for Fun.*

The dramatized series, sponsored by station WHA as a feature of the Wisconsin School of the Air, presents health instruction for students in the upper grades in a manner which stimulates lasting interest. The program is scheduled for Mondays at 1:30 p. m. beginning September 16. As it is re-broadcast simultaneously by the Stevens Point station WLBL, it can be heard in almost every county of the state.

Class of upper grade students listening to *Fit for Fun* radio health program.

Letters written by the children have reflected the effectiveness of the manner of teaching used in the series, presented under the title, *Fit for Service* for the last two years. Last year, 1,390 schools in the state with a total listening group of 22,240 children used the course, and physicians are urged by the committee to make the figures increase this year. Letters have been sent out to school administrators and county superintendents urging participation of their schools in the course.

The 1946–47 course is divided into four sections, each treating a different subject; dental health, nutrition, accidents, and disease.

Fit for Fun is planned by the University station, WHA, in cooperation with the State Board of Health, the Department of Public Instruction, the State Medical Society and the State Dental Society of Wisconsin, and is part of the Wisconsin Cooperative School Health Program.

UNIV. MEDICAL SCHOOL FACULTY CHANGES

The University of Wisconsin Medical School announces the following faculty promotions and additions for July 1, 1946 or later:

Promotions:

Walter J. Meek, M. D.—Asst. Dean to Assoc. Dean—Medicine

Ralph E. Campbell, M. D.—Assoc. Prof. to Prof.—Obstetrics & Gynecology

Raymond C. Herrin, M. D.——Assoc. Prof. to Prof.—Physiology

Lester W. Paul, M. D.—Assoc. Prof. to Prof.—Radiology

Frederick J. Pohle, M. D.—Asst. Prof. to Assoc. Prof.—Medicine

Helen A. Dickie, M. D.—Asst. Prof. to Assoc. Prof.—Clinical Medicine

Edgar S. Gordon, M. D.—Asst. Prof. to Assoc. Prof.—Medicine

Frank L. Kozelka, M. D.—Asst. Prof. to Assoc. Prof.—Toxicology

Thelma Hruza, M. D.—Inst. to Asst. Prof. Clinical Neuropsychiatry—Student Health

Ruth Dickie—Inst. to Asst. Prof.—Dietetics

James A. Miller, M. D.—Inst. to Asst. Prof.—Cancer Research

Margaret A. Kohli—Inst. to Asst. Prof.—Physical Medicine

Carolyn Thompson—Inst. to Asst. Prof.—Occupational Therapy

Joanne Martin—Asst. to Inst.—Nursing.

New Additions:

Sture A. M. Johnson, M. D.—Prof. Dermatology (9/1/46)

Llewellyn R. Cole, M. D.—Prof. Clin. Med. & Coordinator of Grad. Med. Educ.

Carol M. Rice, M. D.—Assoc. Prof. Clin. Med. & Asst. Dir.—Student Health

Martha Jenny—Assoc. Prof.—Nursing

Jacob W. Stutzman, M. D.—Asst. Prof.—Physiology

Myrtle Mac Miles—Asst. Prof.—Anatomy

John L. Sims, M. D.—Instr.—Medicine

Elizabeth A. Clark, M. D.—Instr.—Radiology

George E. Kambara, M. D.—Instr.—Ophth., Surgery

Henry M. Suckle, M. D.—Instr.—Surgery

Frederick G. Joachim, M. D.—Instr.—Anatomy

Edith Jones—Research Asst.—Bacteriology

Edna Kearney—Grad. Asst.—Bacteriology

STATE HISTORICAL SOC. HONORS DR. BEAUMONT, PIONEER PHYSICIAN

Speeches Will be Given at Prairie du Chien

Dr. William Beaumont, early 19th century pioneer physician in the field of gastric experiments, will be honored at one of the sessions of the State Historical Society's annual meeting, August 23 and 24, at Prairie du Chien.

Dr. Arno Luckhardt, University of Chicago physiologist, will discuss Doctor Beaumont's work and his contributions to medical science Friday morning, August 23, at Campion College.

In May, a play written by Prof. Robert Gard, who came to the University of Wisconsin to organize the "Wisconsin Idea" Theater, "The Man With the Lid on his Belly," dramatizing Doctor Beaumont's experiments at the historic river city, then called Fort Crawford, was produced at Prairie du Chien. The play was a feature of the 10th annual opening of the Villa Louis, historic residence of Colonel Hercules Dousman.

VA EXPANDS PROGRAM—

(Continued from page 7)

Thirty-two clinics for mentally sick veterans previously had been authorized for various metropolitan areas and approximately half are now fully staffed and operating.

In the mental hygiene program, group therapy will be emphasized, providing for maximum utilization of the limited number of psychiatrists on duty. When facilities and time are available and when the patient's condition requires it, individual treatment will be provided.

Will Work as Team

The neuropsychiatrist, clinical psychologist, and social worker will co-operate as a team in treating the patient so that all aspects of his sickness may be studied by experts. As a general working plan, the team is composed of one psychiatrist, one clinical psychologist, and two social workers for each group of 50 patients.

VOLUNTARY MEDICAL CARE PLAN FORMED IN VERMONT

The Secretary of State of Vermont, in April, 1946, issued articles of association to the Vermont Physicians Service, Inc., a non-profit corporation formed under a special enabling act, to offer medical and surgical coverage to the people of Vermont.

The action to organize a voluntary prepaid plan for medical and surgical care in the state originated in October, 1945, when the Vermont State Medical Society, by its House of Delegates, authorized the inauguration.

Plans call for the company to be controlled by the members of the medical profession, and an office to be established in the headquarters of the Vermont State Medical Society at Rutland.

The Board of Trustees, meeting for the first time May 5, considered the details of contracts and rates and submitted them to the Vermont State Commissioner of Banking and Insurance.

Financed by Contributions

Arrangements have been made to finance the plan by contributions from physicians. A guaranty fund not to exceed $10,000 will be established, and an estimated $8,000, needed for organizing and operating expenses, will be contributed at approximately $75 per capita for the contributing members of the Vermont State Medical Society.

The
MEDICAL FORUM

The Wisconsin Medical Journal September, 1946

COOPERATIVES FORM NEW NATIONAL ORGANIZATION

President Truman Signs Hospital Survey and Construction Bill

States Will Receive Grants After Surveys Completed

Washington, D.C.—With the signing of the Hill–Burton Hospital Construction and Survey Bill (S. 191) by President Truman August 13, an appropriation of $3,000,000 was authorized for statewide hospital surveys and planning of construction programs. The act also authorized $75,000,000 annually for five years for the actual construction of hospitals and related facilities. The surveys must be conducted before federal funds are granted to the states for construction work.

While the appropriation for construction is authorized now, it can go into effect and the money be alloted to the states only if a separate appropriation is passed by Congress at its next session in January.

Surgeon General Comments

"This act sets for the first time a national policy which makes it clear that hospitals in the future must be planned, located and operated in relation to the overall health needs of the people," Thomas Parran, Surgeon General, U. S. Public Health Service said.

Funds for survey purposes may be assigned to Wisconsin, as to the other states, only if the state appropriates two-thirds of the money needed for the survey. If the Wisconsin legislature does authorize provision of the necessary funds—two-thirds of the total—the state will probably not receive the federal funds for construction of hospitals until about July of 1947.

Under the act each state would develop its own program of survey and construction, administered by state authorities under the U.S.P.H.S. specified standards. The state would designate a single state agency to carry out the survey and planning and would appoint a properly qualified advisory council to consult with the state agency.

The share of the $3,000,000 that each state may receive for survey and planning expenses is based solely on population. Actual construction allotments per state are determined, after the survey is completed, by population and aver-

(Continued on page 3, column 3)

Farm Accidents Are Too Frequent, Survey Shows

"Farm accidents are all too frequent—more so than has been generally recognized," reports Dr. R. L. MacCornack of Whitehall, who has been conducting a survey of farm and rural accidents of the past year with the general surgical division of the MacCornack Clinic.

The survey shows that the total number of accidents in approximately a year's study in the Whitehall, Wisconsin, area is 309 cases, including 244 adults and 65 children, the doctor recounts, and five were fatalities. "It is evident that this is a great number in the comparatively small area around Whitehall. If this number is multiplied by the number of similar communities throughout the United States, it is true that the suffering, loss of time and life, is more than twice what it should be." Doctor MacCornack states, continuing, "We believe that fatigue, carelessness and haste are three important factors in causing accidents."

Further reports on the survey will come from the Committee on Rural Health and Accident Prevention, of which Doctor MacCornack is a member, at a later date.

DECLARE MEDICAL CARE BELONGS TO THE CONSUMER

Meeting at Two Harbors, Minnesota, August 15–18, delegates to a conference on cooperative health plans formed a new national organization, the Co-operative Health Federation of America, proposing to direct and coordinate cooperative health plans on a national basis.

Educational, political and governmental agencies were represented by the 200 delegates and visitors from 20 or more states, 4 provinces of Canada, Hawaii, and Nova Scotia.

With "medical care belongs to the consumer" as a basic theme, speeches and discussions covered all phases of cooperative plans.

Claiming "medically owned or controlled plans provide only protection against catastrophic illness and that's about all that you can get out of them," Dr. John B. Lawrence, associate director and staff member of the Group Health Association and Labor Health Institute of St. Louis, Missouri, discussed consumer control in the first speech of the four day session. The doctor emphasized that as a matter of human right, medical service belongs to the consumer, that the producer (the physician) cannot provide the leadership that the consumer can in the distribution of medical service, the maintenance of its quality and character. Doctor Lawrence said that real group practice and adequate distribution of health facilities, specialists, and medical care for the rural areas can be developed only through cooperative programs.

Doctor Shadid Criticizes A. M. A.

In discussing his difficulties in developing his cooperative institution, Dr. Michael Shadid, founder of the Elk City Hospital in Oklahoma, a speaker of the second day

(Continued on page 2, column 1)

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA

COOP. ORGANIZATION—

(Continued from page 1)

of the conference, criticized the American Medical Association for not providing assistance, and emphatically stated that the A. M. A. has been callous, ruthless, and contemptuous of public interest, and that it stands convicted before the bar of public opinion of a crime and a misdemeanor.

Another of the speakers, Dr. Kingsley Roberts, director of the Medical Administration Service, Inc. of New York City, in an extemporaneous talk, listed seven points for a basic health conservation and prepaid medical care program. He warned the group that regardless of what it was named, they must remember that they were "dealing in the long run with the problem of insurance."

Doctor Emerson Supports A. M. A.

Addressing the conference delegates on several points made by Doctor Roberts, Dr. Haven Emerson, professor emeritus of public health of Columbia University, declared that the public must keep in mind that the sights had been set by the medical profession, and that it has not been indifferent or sluggish as had been suggested, but that any failure has been a failure of public interest, not a failure on the part of the profession.

"For example," Doctor Emerson explained, "the American Medical Association many years ago took a pointed position on the necessity of periodic health examinations but despite its publicity and the work of its membership, the public has continued indifferent to its necessity."

Saying that the greatest legal problem of cooperatives comes from the almost "universal prohibition against corporate practice of medicine," H. R. Hansen, legal counsel for the Group Health Mutual of St. Paul, gave the reasons followed by the courts but expressed his opinion that the law should not apply to nonprofit cooperatives because with members controlling the program there is no incentive to exploit that plan commercially, and because the members receiving the service and the cooperatives are one and the same, and hence the legal fiction that a corporate entity is engaged in the practice of medicine, is inapplicable.

One afternoon of the conference was devoted to discussion of organizational problems, with delegates describing reactions and cooperation with the movement of cooperatives in various areas of the country.

At another meeting, Dr. Haven Emerson proposed a plan of cooperation of patients with self-chosen physicians. He advised that the program be devoted to the cooperative type of voluntary movement, opposing the Wagner, Murray, Dingell proposed program.

Purposes of Organization Put in Resolution

The August 18 morning session of the conference was concerned with the business problems of organizing a national federation of cooperative health plans. A resolution, formulated during the conference days, was introduced at the close of the business session and was later passed.

In the resolution setting forth its aims and purposes, the conference approved the principal of public responsibility for assuring the availability of health and medical services for all the people without economic barriers, and therefore supporting proposals for larger grants to the states for public health purposes and nation-

(Continued on page 5, column 1)

SMS State Fair Exhibit Features Food Values With Live Animal Displays

The 1946 State Fair exhibit presented by the State Medical Society, in cooperation with the biochemistry department of the University of Wisconsin, the Nutrition Unit of the State Board of Health, and the American Medical Association featured food values, as graphically portrayed in two live animal displays.

The importance of a well-rounded diet was emphasized through an exhibit of white rats, prepared by graduate students of the biochemistry department. One control group was fed a limited diet of grain and water, while the other group was fed a complete diet of milk, vegetables, meat, and grain. At the end of three weeks, when the State Fair exhibit was presented, the initial group, fed on a marginal diet, was half the size of the group fed a complete diet.

The SMS exhibit attracted a great deal of attention, particularly from the thousands of young people who visited the Junior Fair Building, where the exhibit was housed. From comments overheard by attendants it was evident that many young people who viewed the exhibit were impressed with the educational lessons on nutrition portrayed.

SMS exhibit at State Fair showing cages of rats and photographs demonstrating the effects of limited and adequate diets.

WISCONSIN COOPERATIVE ASSOCIATION ASSAILS STATE MEDICAL SOCIETY

Claim Fence Law Exists

Insurance Commissioner Points to Fallacy in Its Argument

Continuing to criticize the State Medical Society as "uncompromising" and as an organization of "medical politicians," the Wisconsin Association of Cooperatives announces that it will press for the repeal of the enabling legislation in prepaid medical care insurance granted the State Medical Society and county societies in manner approved by the State Society by the 1945 session of the legislature.

In substance, this act, which had the endorsement of Governor Goodland, enabled medical societies to go beyond the indigent and low-income group in operating plans of prepaid medical care, and clarified the status of such plans under the insurance laws. The Wisconsin Association of Cooperatives sought to amend the measure so that *any* cooperative or labor union, without regard to other laws of the state, might establish similar programs. The Society opposed this amendment on two grounds—that it was not germane to a law that pertained only to medical societies, and that in any event cooperatives should be more specific in their intent.

Announce Legislative Drive

The Wisconsin Cooperative Association now states that the Medical Society enabling act constitutes a "fence" law since it does not include cooperatives. Terming the law "un-American," the association announces that the repeal "drive" will have support from other sources as well.

Assemblyman Acts

Asking whether insurance laws of Wisconsin are designed "as a penalty to organizers or as a protection to the public," Assemblyman Vernon W. Thomson, sponsor of the Society's enabling legislation, recently asked the opinion of Commissioner Morvin Duel of the State Insurance Commission to clarify the situation. Mr. Thomson stated that on a number of occasions inquiries had been made of him as to the effect of the law on the basis that in "some way it acts as a 'fence' or other obstruction to the entry of co-ops into the low cost prepaid health insurance plans."

"For my own part," said Mr. Thomson, "I am satisfied that this was not intended and is not the effect of the law . . . I ask the benefit of your special knowledge in answer to the following questions:

"1. The legal status of domestic co-ops under the Wisconsin insurance laws.

"2. Does Chapter 494, Laws of Wisconsin, 1945 (amending Chapter 148), or any other part of that chapter, serve to obstruct the operation by co-ops of low cost prepaid health insurance plans.

"3. Isn't there some valid basis for exempting prepaid sickness care plans, esablished by the State Medical Society, or by county societies, from certain, at least, of the requirements imposed upon insurance companies.

"4. Isn't it a fact that State Medical Society prepaid sickness care plans must comply with certain provisions of the insurance laws.

"5. Are insurance laws designed as a penalty to organizers or as a protection to the public."

Insurance Commission Clarifies

Commissioner Duel replied that so far as "I can determine that enabling act had no concern whatever with co-ops . . . The act does not even mention co-ops at any point nor would it have seemed appropriate to . . . have had any provisions relating to co-ops in a medical society statute."

Noting that the Blue Cross plans existed under somewhat similar legislation, Commissioner Duel pointed out that both medical society and hospital care plans fall into the same general category for "each is a non-profit service organization. One has special resources assuring the delivery of hospital service and the other for medical care."

Insurance laws are for the protection of the public, Duel emphasized, and co-operative organizations wishing to engage in that

(Continued on page 6, column 3)

HOSPITAL BILL—

(Continued from page 1)

age per capita income data. Again, as with the funds for survey, federal funds may not exceed one-third of the cost of the project.

Estimate For Wisconsin

Preliminary estimates given by the U. S. P. H. S. indicate that Wisconsin may receive $31,000 for survey and planning purposes, and $1,622,925 for construction if the appropriations are approved and matched in funds two to one.

The American Hospital Association reports that as of August 13, surveys were underway in 40 states, 7 states were organizing surveys, and only one state had taken no action. The association says it is expected that surveys will be completed in at least 11 states by October 1.

RUSH

Your patient is often our policyholder. When he presents you with one of our claim blanks, you will be helping him tremendously by completing it immediately.

Our claim blanks are intended to be simple, because your answers to our questions are important to prompt payment of claims. Please, doctor, don't delay those claim reports, and thanks.

(If you have any ideas as to how our claim reports could be made more clear—we're listening!)

The Time

Insurance Company

213 W Wisconsin Ave.

Milwaukee 3, Wis.

Capital Times Criticizes; SMS Points to Impartial Guest Editorial Policy

Appearing in the columns of the Capital Times, Madison newspaper, on July 23, was an editorial criticizing the *Wisconsin Medical Journal* for printing a guest editorial by Senator Robert A. Taft on a national health plan the senator presented to the United States Senate, in its July issue. The newspaper editorial follows in full:

Sen. Taft And The State Medical Society Find Common Cause

There is an old adage about "birds of a feather" which applies very well to the appearance of Sen. Robert A. Taft as the guest editorialist in the current issue of the Wisconsin Medical Journal, the publication of the State Medical Society of Wisconsin.

* * *

Sen. Taft and the State Medical Society were bound to get together sooner or later. They couldn't both be playing the same kind of a game of stalling adequate health plans for the state and nation without discovering that in unity there is strength.

Sen. Taft has been leading the fight in Washington against the medical insurance program provided by the Wagner–Murray–Dingell bill, as he has led the fight against virtually every progressive measure proposed in Washington since he has been there. To stall this vital health bill he has offered a weak and totally inadequate bill of his own.

The people of Wisconsin will recognize Sen. Taft's strategy. It's the same strategy being used by the politicians in the State Medical Society of Wisconsin. In an effort to ward off the establishment of a comprehensive medical program in this state, they have offered, with thundering fanfare, a phoney program of their own.

The inadequacy of the program has been recognized by the house of delegates of the State Society. At a recent session the profession went on record favoring expansion and liberalization of the present plan. As the Milwaukee Journal has pointed out, this mandate has been ignored by officials of the Society, who are still plugging the narrow, restrictive features of the original plan.

It is not surprising, therefore, that Sen. Taft should find a prominent spot in the Wisconsin Medical Journal. Obstructionists always have and always will make common cause.

On August 4, the newspaper printed the letter of Mr. C. H. Crownhart, Secretary of the State Medical Society, addressed to Mr. William Evjue, editor, in response to the Capital Times' censorious article, explaining the *Journal's* editorial policy. The letter follows:

Calls Attention Wagner, Pepper Articles

(Madison, July 24,)—I have read your editorial of July 23 criticizing the State Medical Society of Wisconsin for publishing in The Wisconsin Medical Journal a guest editorial by Sen. Robert A. Taft which explains the recent national health program he has offered in the United States senate.

It seems entirely possible that your staff has failed to direct your attention to other guest editorials that have appeared in The Wisconsin Medical Journal, including those of United States Sen. Robert F. Wagner and Claude Pepper, who have presented health measures of their own.

In keeping with an established policy of providing our readers with both sides of current issues, these and many others have been solicited by the society. The issues of The Journal in which those particular editorials were presented are enclosed.—C. H. Crownhart, Secretary, The State Medical Society of Wisconsin.

Mr. Doran Heads New Veterans Medical Service Agency

At the June session of the House of Delegates of the State Medical Society, a committee was appointed to develop plans and a contract with the Veterans Administration for the care of veterans on a free choice of physicians basis.

The fee schedule and the contract setting up a Veterans Medical Service Agency were signed by the VA on August 30, according to Mr. Thomas Doran, city relief director on leave of absence, who is in charge of the new agency.

State Journal Photo
THOMAS J. DORAN

Until the service agency was formed, veterans had to go to the Veterans Administration physicians for treatment of all disabilities that were service connected and for which payment is required through a government agency.

Headquarters for the Veterans Medical Service Agency have been obtained in the Washington Building, Madison, and the plan is expected to be in operation by November, Dr. J. S. Supernaw, chairman of the State Medical Society committee to set up the agency, reports. Other physicians on the committee are: Drs. W. C. Finn, Fond du Lac; Maurice Hardgrove, Milwaukee; H. S. Fuson, Eau Claire; and F. D. Weeks, Ashland.

Considerable time and effort have been spent by the committee in drafting and simplifying the forms that the doctors will use in examination and medical findings of the veterans. The forms are being printed and will be sent to each member of the State Medical Society who signifies his intention of participating in this veterans program. Before the program starts each SMS member will receive a detailed letter explaining the program and will have the opportunity to sign a card that will automatically place his name on the list of participating physicians.

Negotiations are now in process between the agency and the State Department of Veterans Affairs to arrange for the use by both groups of the same fee schedule and the same forms for filling out information concerning veterans.

Newly Formed Cooperative Health Unit Object of AMA Editorial

COOP. ORGANIZATION—

(Continued from page 2)

wide health insurance under public auspices, providing:

(1) That all services provided through government should be available to all the people on a democratic basis.

(2) That any public insurance proposal to receive its support must assure the continuation and expansion of the voluntary health and medical service agencies on a basis that will permit consumer control of administrative and organization policies. Such public insurance plan must further provide freedom for the establishment of new medical service groups with consumer determination of policies.

(3) That as a condition for state participation in the national health program, there shall be no state policies legal or otherwise, that restrict the free development of consumer-sponsored medical service plans.

(4) That programs of preventive medicine and public health, including service for mothers and children, will be broadly conceived and administered.

(5) That the government would share responsibility for a more favorable distribution of medical personnel and facilities.

(6) That there be a maximum decentralization of administration and local control.

Separate Optometry Corps Stopped by Short Bill Veto

Optometrists fighting for the establishment of a separate Optometry Corps in the Medical Department of the Army received a setback recently when President Truman vetoed H. R. 3755, the Short bill, which would have established such a corps. However, they have not given up the fight.

In the opinion of President Truman, the creation of an Optometry Corps would not be harmonious with the present structure of the Medical Corps nor with the proposed organization of the postwar Army Medical Department. "Medical care," the President commented, "must be directed by officers professionally trained to recognize pathologic conditions."

Journal Attacts Federation Charge That All Medical Care Programs Now in Operation Are "Monopolistic"*

The new Cooperative Health Federation of America, which was organized recently at Two Harbors, Minn., for the purpose of pooling the strength of all organizations seeking medical services, was termed by *The Journal of the American Medical Association* as an "orchestra of virtuosos with each of the players trying to lead in a different beat of time."

In its August 31 issue, *The Journal* says the sponsors "want to bring the world under consumer control," adding: "In short, they want to change the very concept of most Americans as to the American way of life 'even by compulsion.'"

The editorial says:

A national organization, the Cooperative Health Federation of America, to further "consumer controlled" group medical care, was initiated at Two Harbors, Minn., August 18. This organization, which would bring together varied and diversified groups, was the result of a four day conference attended by some two hundred delegates and visitors from more than twenty states, the District of Columbia and Hawaii and four provinces in Canada. The backbone of the conference was made up of those interested in farm cooperatives, but local labor and federal government representatives were present and often vocal.

Employees of the federal government bureaucracies attended in considerable numbers. Judging from their comments during the conference, both public and private, their purpose was to enlist approval for some form of the federal legislative program of compulsory sickness insurance. Several of these government agents were registered as being connected with Group Health, Inc., at Washington, but were actually employed by the Farm Security Administration and the Children's Bureau; they concentrated their efforts on bringing the government's compulsory health insurance program before the conference. As will appear later, they succeeded in having some of their ideas written into the conference program.

"Consumer control" of medical care, the theme song of Michael Davis [CIO Political Action Committee], was the theme of the conference. All prepayment medical care programs developed by state and local medical societies were characterized as "monopolistic." At first these programs were almost totally ignored; then they were, so to speak, "outlawed" by the conference, which went on record as unanimously endorsing "the principle of nationwide health insurance" with provisions fostering voluntary patient control services with consumer representation on national, state and local administrative boards and a ban against states "that restrict the free development of consumer-sponsored medical plans."

James P. Warbasse, M. D., president emeritus of the Cooperative League of the United States, is the esteemed major prophet and Michael Shadid, M. D., founder and director of the Community Hospital, Elk City, Okla., the professional martyr for the "consumer" cooperative group. Dr. Warbasse was not present; his message to the conference called for the creation of a new branch of medicine to be known as "Cooperative Hygiene." Dr. Shadid related again the difficulties he encountered in getting his group established at Elk City. He concluded his remarks by stating that "American medicine stands convicted of crime and misdemeanor at the bar of public opinion." He stated that if the American Medical Association does not lend its support to group practice (such as his) he would recommend a federalization of all groups on behalf of compulsory health insurance. Especially critical of the point of view of the medical profession were the representatives of the Labor Health Institute of St. Louis—Dr. Elmer Richman and Dr. John B. Lawrence. Kingsley Roberts, M. D., director of Medical Administrative Service, Inc., of New York City, highlighted an informal talk with a statement that all prepayment plans, "no matter what you call them," are insurance. One physician who directs a group practice in San Diego, Calif., brought his own publicity and public relations man with him.

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* From the *American Medical Association News.*

EDITORIAL IN AMA JOURNAL ATTACKS TECHNICS USED IN WAGNER-MURRAY-DINGELL BILL HEARINGS

Says Might Be Foretaste of Operations of National Compulsory Sickness Insurance

Commenting editorially on the technics employed in the conduction of the hearings on the Wagner–Murray–Dingell bill before the Senate Committee on Education and Labor, which were concluded recently, *The Journal of the American Medical Association* in the August 24 issue states as follows:

"*The Journal* suggested in reporting the first day of this extraordinary manifestation of the workings of a democracy, that the whole performance had been developed by Messrs. Wagner, Murray, Pepper, Dingell et al.—which includes, of course, their associates, such as employees of the Social Security Board and Michael Davis —as propaganda in behalf of the contemplated legislation. An analysis of the hearings indicates that more persons were heard favorable to the legislation than unfavorable and that many of those unfavorable to the legislation who were of professional or public stature equal to or greater than those who appeared for it were not permitted to have their say. The technics employed in conducting these hearings might well be considered a foretaste of the operations of national compulsory sickness insurance if the Wagner–Murray–Dingell bill should be enacted.

"Evidence brought out in the hearings through the astute questioning of Senator Donnell revealed the nature of the little groups marshaled behind the legislation, including the so-called Committee on the Nation's Health, the Committee for Medical Care and the Physicians Forum. Pitiful, indeed, was the exhibition by Dr. Channing Frothingham, whose testimony revealed how he was made a front for the propaganda group assembled by Michael Davis and how little he knew of the actual workings of the organization that he heads. Apparently he was unable to remember the names of his associates; after condemning the writings of some of those opposed to the measure, he indicated that he had never read them.

"The hearings served, moreover, to bring to light the problems that the medical profession must face and the persons who use public office to exalt their bureaucracies. There too were the executive secretaries of various pressure groups who presume to speak for considerable numbers of people whose views they have never ascertained.

"The incisive questioning by Senator Donnell established definitely that there can be no free choice of physician by patient under any government controlled medical service, that nationalization lends itself to the political degradation of medical practice, that it makes the politician the important figure in medical care, that it takes from the physician his right to practice his profession as a scientist and that it is in every sense a 'taking over of medicine by the state.'

"Outstanding also were the comments even by those who opposed the point of view of the American Medical Association—and, incidentally, of the vast majority of high scientific status of the medical profession, their respect for physicians as a profession, their esteem for the publications of the American Medical Association and their recognition that it was the physicians themselves, through their organization, that raised the standards of medical education, improved the quality of our hospitals, eliminated quackery, promoted scientific research, participated with public health officials in lowering sickness and death rates and made possible through their magnificent service in the armed forces the winning of the war."

CLAYTON FONDREN APPOINTED AS ASSOCIATE EXECUTIVE SECRETARY, OKLAHOMA MEDICAL ASSOCIATION

Oklahoma City, Okla., Aug. 20—Mr. Clayton Fondren of Oklahoma City has been appointed associate executive secretary of the Oklahoma State Medical Association, Dr. L. C. Kuyrkendall, president of the association, announced today.

Mr. Fondren, who will work with the executive office at 210 Plaza Court, Oklahoma City, is a graduate of the University of Oklahoma, and served 48 months with the Army Air Forces.

Thanks, Ted

"In and Out of Focus," a feature of the Medical Annals of the District of Columbia, is written by Mr. Theodore Wiprud, Secretary of the D. C. Society, and former Executive Secretary of the Medical Society in Milwaukee County. Mr. Wiprud's column is devoted to an analysis of current medical writings and reactions. Reviewing various state activities, Mr. Wiprud has this to say of the Journal's Medical Forum:

"If he remembers correctly, your Observer has commented before on the excellence of some state medical journals. In this select company is the *Wisconsin Medical Journal.* One of its outstanding features is 'The Medical Forum,' a newsy, informative department which contains all the latest, up-to-the-minute news on the social and economic problems of medicine. The *Journal* is to be commended on this distinctive and worthwhile feature."

WIS. COOP. ASSOC.—

(Continued from page 3)

field have always been subject to them. Mr. Duel's reply follows in full:

The State of Wisconsin
Department of Insurance
Madison 2

August 9, 1946

Hon. Vernon W. Thomson,
Richland Center,
Wisconsin.

Re: Co-ops and the State Insurance Laws

Dear Sir: Your recent inquiry as to the legal status of co-ops under the Wisconsin insurance laws is one of a number recently received on this subject. Because of the apparent confusion which exists, I think it may be helpful to clarify a few fundamental points. Co-ops, by which I mean cooperative associations organized under Chapter 185 of the Wisconsin Statutes, which are interested in doing insurance business have always been subject to the insurance statutes of this state. The 1945 legislature made no changes in this respect. There are now several organizations in this state which deal almost exclusively with coop-

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WIS. COOP. ASSOC.—

(Continued from page 6)

erative groups organized and authorized to write insurance in such diverse fields as automabile, fire and life insurance. Each of these cooperative insurance companies was required to fulfill all the obligations imposed by law for ordinary insurance companies, and they have all done so in fact.

In answer to your second question, I must answer in the negative, because so far as I can determine, that enabling act had no concern whatever with co-ops. This law, relating as it does to the establishment of sickness care plans by state or county medical societies was enacted in part as an amendment and in part as an addition to Chapter 148 of the Statutes, entitled "Medical Societies." The act does not even mention co-ops at any point, nor would it have seemed appropriate to the writer to have had any provisions relating to co-ops in a Medical Society statute.

In answer to your third point, this is a question of public policy. I call your attention, however, to Section 180.32 of the Wisconsin Statutes, which is the enabling act for Wisconsin Blue Cross. It is reasonable to consider a hospital service plan and a sickness care plan established by a medical society as falling within the same

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Representatives of "Wisconsin Plan" Insurance Companies Meet in Milwaukee

Meeting at the Milwaukee Athletic Club, Milwaukee, August 28, representatives of participating insurance companies writing the "Wisconsin Plan," prepaid surgical, obstetric, and hospital insurance, discussed problems and procedures of the participating companies.

Following discussion of how to increase the salability of the "Wisconsin Plan," the representatives considered an advertising and publicity program; raising the income level, thus enabling more people to use the plan; and making the hospital benefits more flexible.

Twenty-Five Companies Participating

A report presented showed that as of July 31, 1946, 177 groups were covered by the "Wisconsin Plan," or a total of 25,441 persons. Twenty-five insurance companies are now participating in the plan. They are as follows: Aetna Life, American Mutual Liability, Benefit Association of Railway Employees, Business Men's Assurance, Celina Mutual Casualty, Continental Assurance, Continental Casualty, Employers Mutual Liability, Federal Casualty, Great Northern Life, Hardware Mutual Casualty, Illinois Mutual Casualty, Liberty Mutual, Lincoln National Life, Lumbermens Mutual Casualty, Mutual Indemnity, North American Accident, North American Life and Casualty, Old Line Life, Personal Indemnity, Provident Life and Accident, Time, Washington National, Wisconsin National Life, and Woodmen Accident.

A booklet, the 1946 registry of participating physicians who are agreed to render care under the terms of the "Wisconsin Plan," was distributed to the representatives at the meeting and is available to all doctors.

Representatives of insurance companies writing the "Wisconsin Plan" discuss problems and advances at a recent meeting in the Milwaukee Athletic Club.

AMA HEALTH EDITORIAL

(Continued from page 5)

The air of mystery surrounding the position of the government spokesmen was typified by Harry Becker, who appeared on the program as president of Group Health Association of Washington, D. C., but who is actually connected with the Children's Bureau. Although Kenneth Pohlmann, who is employed by the Farm Security Administration but was registered under Group Health, Inc., was not on the program, he was an ardent worker in promoting the government view before the conference. Despite the enthusiastic advocacy of the cooperative consumer theme by many speakers, Dean Clark, M. D., medical director, Health Insurance Plans of Greater New York, New York City, warned of the difficulties and pitfalls in establishing group practice plans and made an objective professional presentation on the subject of evaluation of voluntary health plans. Cecil R. Crews of the Consumer Cooperative Association of Kansas City gave an interesting outline of the cooperative health movement which bypassed completely prepayment plans sponsored by medical societies.

Margaret C. Klem of the Division of Health and Disability Study of the Social Security Board gave full recognition to the work being done by the Council on Medical Service of the American Medical Association in the prepayment field. Frequently during the conference Dr. Haven Emerson took the floor in both formal and informal discussions and told how the American Medical Association and the medical profession were leading the country in public health education work and in the field of preventive medicine as well as in the sponsorship of prepayment medical care programs. Time and again he tried to raise the sights of the conference from an attack on the medical profession and the American Medical Association to a constructive approach to the problem. Essentially he feels that more recognition must be given the cooperative movement by American medicine.

The conference suggested that the new Wagner–Murray–Dingell bill should embody the following points:

1. Provide for the distribution and training of medical personnel.

2. Encourage voluntary plans and group practice by loans or subsidies and sponsor an educational program.

3. Establish minimum standards for groups.

4. Promote research and preventive medicine.

5. Make sure that the beneficiary designates the plan by guaranteeing the freedom of the association or group and providing that any state restricting the formation of plans should not receive state aid.

6. Extend coverage to include federal employees.

7. Assure local control with consumer participation.

For the most part, those who attended the conference appeared to be ardent, sincere, crusading advocates of rapid and all inclusive changes in the medical world. They want to change the Principles of Medical Ethics; they want to change medical education; they want to change the present methods of medical practice. The patient-physician relationship, they insist, is a mere fetish; they want to change state laws; they want to outlaw many states in which medical service plans developed by county and state medical societies have legal recognition. They advocate that the cooperatives themselves enter the manufacturing of surgical and medical supplies. They want to change the balance of influence so that the doctors will become technicians rather than leaders in the medical care program. They want to bring the world under consumer control. In short, they want to change the very concept of most Americans as to the American way of life "even by compulsion."

This catalogue of a revolutionary platform should cause physicians considerable concern. Here was an orchestra of virtuosos with each of the players trying to lead in a different beat of the time. Amidst the cacophony came occasionally a theme of hate for the American Medical Association. And while for a moment they seemed united in approving a program of conduct, each will be found sounding his own particular tune at the next concert.

THE FIRST STEP

Does the Federal Government give you a life-insurance policy? Does Uncle Sam furnish fire insurance on your home and household goods? Or windstorm insurance? Or burglar insurance? Or accident, theft, and fire insurance on your car? Don't be silly; of course not! A few lines in a letter to the New York Herald Tribune Monday, July 1, brings out that point this way:

> "If there is a belief among certain individuals that health insurance is a good investment, let it be placed on a voluntary basis —as is life insurance. Indeed, in a democracy it can be on no other basis—else we have no democracy."

Let the sickness-insurance camel get his nose in the tent, and the next step will be for the Government to take over all the functions of all the private insurance companies.—*Christian Science Monitor.*

WIS. COOP. ASSOC.—

(Continued from page 7)

general category. Each of these is a non-profit service organization. One has special resources assuring the delivery of hospital service and the other for assuring medical care.

It should also be noted in answer to your fourth question that the enabling act requires that any prepaid sickness care plan established under Chapter 148 is subject to insurance statutes relating to nondiscriminatory rates, investment of funds, and premium reserves, and that any new or modified existing plan, and specimen copies of all contracts must be filed with the Commissioner of Insurance.

In answer to your fifth question, no matter how simple an insurance business appears to the uninitiated, the fact remains that it is a highly involved matter these days whether from the standpoint of contracts, selection of risks, reserves or investments. I cannot say with too much emphasis that insurance laws are designed not as obstacle courses for prospective promoters of new companies, but as essential protection for the public which buys insurance, and which is entitled to a maximum for its money.

Very truly yours,
MORVIN DUEL,
Commissioner of Insurance.
MD:RN

The
MEDICAL FORUM

The Wisconsin Medical Journal October, 1946

COUNCIL APPROVES ADDITIONAL MEDICAL CARE PLANS

Council, Advisory Committee Formed to Aid Administration of Hill-Burton Act

Washington, D. C.—Formation of a Federal Hospital Council and an advisory committee to assist Surgeon General Thomas Parran of the U. S. Public Health Service in the administration of the Hospital Survey and Construction Act, was announced September 12 by Federal Security Administrator Watson B. Miller. The first meeting of these groups was held September 17 and 18 in the U. S. Public Health Service Building, Washington, D. C

Long-Range Program

The purpose of the meeting, Mr. Miller said, was to formulate plans for administration of the recently enacted Hill–Burton Act which embodied one important feature of the President's national health program. Mr. Miller characterized this Act as "an epoch in the development of health legislation designed to meet serious and widespread needs," explaining that, "for the first time we are embarked upon a national policy of planning and constructing hospitals and health centers to meet the health needs of the people. For the first time we are creating new institutes not on a sporadic unplanned basis, but on the basis of a long-range, carefully thought out program, integrated to the role that our hospitals and health centers must play in the future."

To carry out this objective Congress has authorized the appropriation of $3,000,000 for surveys and planning and $75,000,000 for 5 years annually for construction. Of these sums, *only $2,350,000 for surveys and planning has been appropriated.*

A state will be eligible to receive construction funds after it has developed a state plan for the construction of needed hospital facilities, based on a statewide survey of existing facilities and existing needs. The state plan will be developed cooperatively by representatives of the state and its local communities and the Federal government based on general standards formulated by the Surgeon General, with the approval of the Federal Hospital Council and the Federal Security Administrator.

In accordance with the provisions of the Act, the Federal Hos-

(Continued on page 6, column 1)

W. J. BLECKWENN NAMED TO MEDICAL ADVISORY COMMITTEE

Madison, Wis., Sept. 27—Dr. William J. Bleckwenn of Madison has been appointed as one of two additional members of the Medical Advisory Committee of the State Department of Veterans Affairs, as suggested by the Council of the State Medical Society at a recent meeting in Madison.

W. J. BLECKWENN

Doctor Bleckwenn, who served for more than five years in the Army Medical Corps, is professor of neuropsychiatry at the University of Wisconsin Medical School, Madison, and assistant director of the Wisconsin Psychiatric Institute.

EIGHTEEN PLANS RECEIVE SEAL OF ACCEPTANCE

Eighteen additional voluntary prepayment medical care plans, sponsored by state and county medical organizations, have been granted the seal of acceptance by the Council on Medical Service of the American Medical Association, bringing to 27 the number approved so far, according to the *American Medical Association News.*

This approval gives the 18 plans, as well as the 9 previously approved, the right to use the American Medical Association blue shield emblem on all official papers and on any promotional literature or display material.

More than 80 voluntary plans sponsored by medical organizations are now operating, and E. J. McCormick, M. D., Toledo Ohio, chairman of the Council, said applications for approval had been received from many of them and would be acted upon soon.

The 18 plans approved at a recent meeting of the Council's executive committee are:

Physicians Association of Clackamas County, Oregon City, Ore.; Hospital Service Corporation, Birmingham, Ala.; Florida Medical Service Corporation, Jacksonville; North Idaho Medical Service Bureau, Lewiston; Genessee Valley Medical Care, Rochester, N. Y.; Hospital Saving Association of North Carolina, Chapel Hill; Oklahoma Physicians Service, Tulsa; Coos Bay Hospital Association, Coos Bay, Ore.; Pacific Hospital Association, Eugene, Ore.; Klamath Medical Service Bureau, Klamath Falls, Ore.; Group Medical and Surgical Service, Dallas, Tex.; The Dallas County Medical Plan, Dallas, Tex.; Surgical Care, Inc., Roanoke, Va.; Medical–Surgical Service, Inc., Clarksburg, W. Va.; Marion County Medical Service, Inc., Fairmont, W. Va.; Medical–Surgical Care, Inc., Parkersburg, W. Va.; the West Virginia Medical Service, Wheeling, and the Hospital Service Association, Oakland, Calif.

The nine plans originally approved are:

California Physicians' Service, San Francisco; Iowa Medical Service, Des Moines; Michigan Medical Serv-

(Continued on page 2, column 1)

COUNCIL APPROVES—

(Continued from page 1)

ice, Detroit; Surgical Care, Inc., Kansas City, Mo.; Nebraska Medical Service, Omaha; Medical-Surgical Plan of New Jersey, Newark; Ohio Medical Indemnity, Inc., Columbus; Medical Surgical Association of Pennsylvania, Harrisburg; and the Oregon Physicians Service, Salem.

The Wisconsin Plan has made application to the Council on Medical Service of the A. M. A. for the seal of approval.

At another session, the Insurance Committee of the Council on Medical Service, meeting with representatives of leading insurance organizations in America created two subcommittees—a committee on cooperation and a committee on rural enrollment. The purpose of the first is to enlist close cooperation among all voluntary groups for rendering health protection, while the second subcommittee will study the best means of affording protection offered by the combined voluntary facilities to people in rural areas.

"The people of America can best obtain protection against the hazards of illness through voluntary health insurance plans," said A. W. Adson, M. D., Rochester, Minn., adding: "Through cooperation and understanding among physicians, voluntary medical care and hospital plan executives and insurance representatives can best provide this coverage for the American people without the interference, red tape and government control which would come with compulsory sickness insurance."

Subcommittee Members

Besides Doctor Adson, members of the subcommittee on cooperation are James R. Miller, M. D., Hartford, Conn., a member of the board of trustees of the American Medical Association and Lester Perry, executive director, Medical Service Association of Pennsylvania, Harrisburg. Ex officio members are Jay C. Ketchum, Detroit, executive vice-president of the Michigan Medical Service and advisor to the Council; Frank Dickinson of the A. M. A. Bureau of Medical Economic Research, and Howard Brower, of the A. M. A. Council on Medical Service.

Members of the subcommittee to study voluntary health protection in rural areas are James R. McVay, M. D., Kansas City, Mo.; F. S. Crockett, M. D., Lafayette, Ind., chairman of the A. M. A. Committee on Rural Health, and L. S. Kleinschmidt, of the Council on Medical Service. Mr. Dickinson was appointed as ex officio member.

Thomas A. Hendricks, Chicago, executive secretary of the Council, said that an invitation would be extended to the Blue Cross Commission of the American Hospital Association and the American Hospital Association itself be represented on both committees.

Private insurance organizations will also be represented on both subcommittees. These will include representatives from the Health and Accident Underwriters Conference, the American Mutual Alliance, the Life Insurance Association of America, and the Association of Casualty and Surety Executives.

At a Chicago meeting of the Associated Medical Care Plans, Oct. 4 and 5, the members of those plans present voted to recommend to the commission of the Associated Medical Care Plans that the Wisconsin Plan be permitted membership. The vote on the question was 14 to 9.

STATE OVER-SUBSCRIBES CANCER DRIVE QUOTA; McLEAN APPOINTED EXECUTIVE DIRECTOR OF STATE DIVISION

Madison, Wis., Oct. 7—The appointment of Mr. Robert McLean of Madison, to the post of executive director of the Wisconsin Division, American Cancer Society, was announced by the society recently.

R. O. McLEAN

Mr. McLean, a native of Pittsburgh, Pa., received a B.A. degree from the University of California at Los Angeles in 1934, and was later employed as an office clerk in California and as field representative and branch office manager of a finance service company in Wisconsin.

Prior to a term of military service in the Navy, Mr. McLean was associated with the State Medical Society as assistant editor of *The Wisconsin Medical Journal.*

State Over-Subscribes Quota in Cancer Drive

The quota of $155,000 for the state, independent of Milwaukee County, was over-subscribed under the active direction of Mr. Folke Becker, Rhinelander, general campaign chairman and Mrs. G. E. Stoddart, Beaver Dam, state commander of the Field Army.

Under the direction of the newly appointed executive director, Mr. Robert McLean, the committee on cancer is making plans for a reorganization of the Wisconsin Division of the American Cancer Society in line with the organizational structure of the national office. Plans are being made to develop lay representation in the form of a board of directors composed of prominent business and industrial leaders representing each of the councilor districts. This board will direct the activities in relation to fund-raising, and consult with the committee on cancer on the development of a state-wide program, including the financing of approved cancer detection centers.

Committee Will Develop Post-Graduate Clinics

Paralleling the activities in relation to fund-raising, the committee on cancer will develop a series of postgraduate clinics devoted to cancer diagnosis and treatment. Plans are being projected for the organization of a course that will extend over a period of years. This program is being developed under the direction of a special committee composed of Drs. A. R. Curreri, Madison, and J. C. Fox of La Crosse, in consultation with Dr. W. S. Bump of Rhinelander, chairman of the committee on cancer, and Dr. W. D. Stovall, director of the State Laboratory of Hygiene, and a pioneer in the cancer program in Wisconsin.

Winnebago State Hospital Overcrowded, Understaffed; Conditions Below Standard

The Winnebago State Hospital, overcrowded for the past several years, faces a condition in 1946 more grave than at any time since it was first occupied in 1873, a year after it was constructed.

It is overcrowded, and understaffed too—as to doctors, nurses, and attendants. The following figures illustrate the condition: the hospital is rated as having capacity space for 740; recent studies indicate that the institution should have a capacity rating of 511, rather than 740; on September 17 there were 902 patients in the hospital. Other days of the year the patient load has been higher. The total load of patients treated in the Winnebago State Hospital during the first two-thirds of 1946 is 1,711, with the usual rate of admittance being about 100 cases a month.

Recently Dr. W. J. Urben, director of the Division of Mental Hygiene, State Department of Public Welfare, and Dr. Byron J. Hughes, superintendent of the institution, examined the American Psychiatric Association's standards in relation to the hospital. According to those standards, the institution should have 20 physicians, 131 nurses, 135 attendants, 19 occupational therapists, 12 physiotherapists, 16 recreational therapists, and 6 social workers. Under the present budget the institution is operating with the following staff: 5 physicians (Doctor Hughes and 4 other physicians,) 14 nurses, 116 attendants, and no occupational therapists, physiotherapists, recreational therapists, or social workers.

The institution is so overcrowded that recreational space and living quarters have been allocated as dormitories. Working under these conditions, with limited medical personnel, it is almost impossible for the staff to facilitate diagnosis, treatment, and rehabilitation of those committed to the institution.

The legislature of 1942 and 1944 was cognizant of this situation and appropriated funds to establish a building program, but with increased costs of building and shortages of material the program has not been started, and the legislature will have to complement existing appropriations to provide the minimum facilities anticipated when existing appropriations were made.

Military Medical Service, Fee Schedule Committees Formed By SMS Council

Military Medical Service Committee

Madison, Wis., Sept. 26—Meeting recently to develop a Committee on Military Medical Service, the Council of the State Medical Society appointed the following men to serve as members of the new committee: Drs. W. A. Ryan, Milwaukee, chairman, R. B. Dryer, Poynette, J. L. Moffett, Platteville, J. S. Wier, Fond du Lac, K. G. Pinegar, Marinette, Milton Finn, Superior, and C. Y. Wiswell, Williams Bay. Dr. James C. Sargent, of Milwaukee, a member of the American Medical Association's Committee on Military Medical Service outlined the problems and duties of such a committee at the meeting.

The committee will work on a state level in connection with the projects developed by the Committee on Military Medical Service of the AMA formed the first part of the year by the Board of Trustees, American Medical Association.

As requested by the AMA, four of the seven members of the state committee are World War II veterans, and three, non-veterans. Doctors Ryan and Dryer served in the Navy in this war, and Doctors Moffett and Wier in the Army.

Committee on Fee Schedules

After consideration of the problem of the increasing number of requests for fee schedules or schedules of benefits in connection with various governmental agencies, the Council, at the same meeting, authorized the appointment of a Committee on Fee Schedules with the following members: Drs. Chalmer Davee, River Falls, chairman, A. W. Burek, Wausau, J. W. Truitt, Milwaukee, O. W. Hurth, Cedarburg, and S. B. Harper, Madison.

The Council formed the committee to study the various problems that have developed and the schedules in use, possibly recommending in the future the development of a uniform fee schedule for governmental agencies, such as is now being utilized in Michigan.

WISCONSIN LABOR CO-OP CONFERENCE IN MILWAUKEE

Over 150 delegates from 48 cities in the midwest attending the Wisconsin Labor Co-op Conference in Milwaukee Sept. 15–16, urged the formation by their unions of committees to study co-ops and to interest other local groups in organizing consumer cooperatives.

Among other formal actions taken at the meetings, the delegates: Resolved that the Wisconsin Federation of Labor, Wisconsin CIO and independent unions be urged to form nonprofit health plans having democratic business control and freedom to contract with doctors for professional services on a per capita or salary basis, and that these health co-ops seek government grants and build their own hospitals.

RUSH

Your patient is often our policyholder. When he presents you with one of our claim blanks, you will be helping him tremendously by completing it immediately.

Our claim blanks are intended to be simple, because your answers to our questions are important to prompt payment of claims. Please, doctor, don't delay those claim reports, and thanks.

(If you have any ideas as to how our claim reports could be made more clear—we're listening!)

The Time Insurance Company

213 W. Wisconsin Ave.
Milwaukee 3, Wis.

AMA Officials, Representatives of Insurance Organizations Confer

Program Calls For Joint Action and Study, Special Committee

Representatives of leading insurance organizations of America, including both private and not-for-profit agencies, met with officials of the American Medical Association Sept. 17, to set in motion a drive to cover millions of American citizens and their families with protection against the cost of sickness.

The program for comprehensive protection of the American people against the economic consequences of ill health calls for:

1. Joint action in the development and promotion of voluntary insurance and prepayment plans.

2. Joint study of unit fee schedules, indemnity and service contracts, and claims and operational problems.

A special joint medical and insurance committee will be established to consider the problem of insuring the rural population against the cost of medical care.

"Both the medical profession and the business of insurance are interested deeply in the current movement to make fully available to the people of the United States the benefits of modern and adequate medical and hospital care," said Dr. E. J. McCormick of Toledo, Ohio, chairman of the Council on Medical Service of the American Medical Association, in summarizing the results of the conference.

"Both groups are in agreement that the objective can be achieved most effectively and economically through the development of voluntary prepayment and insurance plans to cover the expense of medical and hospital care and the development of such plans and the making of them available to the American people can be facilitated greatly by joint study of the problems involved and joint action in their solution."

Coordination of the efforts of these groups will be carried out through appointment of joint committees representing the medical and insurance associations. Conferences will be held at frequent intervals.

Representatives of insurance organizations attending the conference were: Ambrose B. Kelly, Washington, American Mutual Alliance, who acted as co-chairman of the conference; Dr. H. Maynard Rees, Boston, Alfred N. Guertin and John A. Henry, Chicago, American Life Convention; Dr. A. J. Lanza, Dr. Henry G. Ungerleider, Albert Pike, Jr. and W. A. Milliman, New York City, Life Insurance Association of America; Harold R. Gordon, C. O. Pauley, and B. Howland, Chicago Health and Accident Underwriters Conference; J. F. Follmann, Jr., New York, Bureau of Personal Accident and Health Underwriters; Neville Pilling, Chicago, Association of Casualty and Surety Executives, and Dr. Howard E. Wiley and John E. Little, Detroit, National Fraternal Congress.—(News Release, A. M. A., 9–18–46)

NEW CO-OP HEALTH GROUP PLANS EXPANSION DRIVE

In a drive to expand consumer-sponsored medical care plans and co-op owned hospitals, the board of incorporators of the Cooperative Health Federation of America, recently formed at a conference at Two Harbors, Minn., report the signing of incorporation papers and adoption of by-laws, at the National Cooperative Congress, Sept. 9 in Columbus, O. Temporary headquarters of the federation will be in Minneapolis.

Representatives of over 200,000 users of medical and hospital plans under consumer auspices formed the federation, and it was estimated that plans representing another 750,000 users of medical services are eligible for membership.

Executive Committee Officers

Officers of the executive committee that was formed are: Dr. Michael Shadid, president; George Jacobson, secretary-treasurer; Harry Becker, first vice-president; Dr. Elmer Richman, second vice-president; and Cecil Crews, third vice-president.

Mr. Jacobson announced that James Carey, national CIO secretary, Nelson Cruickshank, AFL social security director, and Gladys Talbot Edwards of the Farmers Union, had been accepted on the board of incorporators.

A labor project for medical care, with headquarters in Washington, D. C., will be chairmaned by Harry Becker, president, Group Health Association, Washington, D. C., and John Carson, Washington representative of the Cooperative League was named agent for the federation.

STATE MEDICAL GROUPS TREAT VETERANS IN THIRTEEN STATES

Washington, D. C., Sept. 15—Twenty states have agreed to supply "home town" medical care for veterans with service-connected disabilities, Dr. Paul R. Hawley, chief medical director of the Veterans Administration, announced today.

The program is in operation in 13 states. Contracts with state medical groups have been signed but not yet placed in operation in five states, and in two others (Maryland and Utah) VA has received agreements which have not yet been given final approval.

Doctor Hawley pointed out that the "home town" medical care was available to veterans with service-connected disabilities only when VA facilities such as out-patient clinics could not promptly treat the veterans or if traveling to such a VA facility would involve undue hardship or excessive loss of time from work by the veteran.

The 13 states in which state medical groups are treating veterans include: Michigan, California, Kansas, New Jersey, North Carolina, Washington, Oregon, West Virginia, Maine, Ohio, South Carolina, Illinois and the District of Columbia. The District of Columbia's contract allows only examination of veterans—no treatment.

While Wisconsin is listed as one of the states which is not yet treating the veterans, the Veterans Medical Service Agency for that purpose has been formed and organized, and operations—actual treatment of the veterans—will begin November 1.

States in which contracts have been signed by both VA and the state medical group but which have not yet been put in operation include: Montana, Wisconsin, Idaho, and Pennsylvania.

National Physicians Committee Releases Study on Compulsion

New Book Discusses National Health Program Hearings

Chicago, Ill., Sept. 4—Branding the conduct of the recently-ended public hearings of the Education and Labor Committee of the United States Senate on the so-called National Health Program (S. 1606) as deliberately framed to create a false impression of public support, the National Physicians Committee for the Extension of Medical Service today released a 196 page book entitled "Compulsion—the Key to Collectivism."

In the Foreword, the book states, "Already we are confronted with the establishment of controls and 'lusts for power' never before known in this country . . . There is just one thing that it is essential for the American people to understand: Communism, Fascism, Naziism are not mere matters of terms or definitions. They result from the establishment of centralized controls and the operation of mechanisms of administration . . . If the Wagner–Murray–Dingell proposals were enacted into law they would introduce a compulsory tax to pay for a compulsory service—medical, dental and nursing care—directly affecting the most vital and most sacred functions of each individual citizen of the United States . . ."

The study points out that witnesses permitted to testify before the so-called fact-finding Senate Committee were selected by a "carefully-chosen screening committee," friendly to the proposed legislation, with the result that the final record showed an average of two witnesses appearing in support of Title II of the Wagner–Murray–Dingell Bills for every one permitted to appear in opposition to the Compulsory Health Insurance provision of the measure —this despite urgent requests from hundreds of practicing physicians for an opportunity to be heard in opposition.

The list of witnesses in favor of "Political Medicine" was heavily loaded with Federal payrollers and Leftist group representatives—"a perfectly normal pattern of bureaucrats at work in quest of more and more power over the lives of the people," according to the National Physicians Committee.

A chapter of the book reviewing the historical background of the agitation for Compulsory Sickness Insurance in the United States asserts that the Wagner–Murray–Dingell Bills are not of American conception, but are patterned after a model formulated by the International Labour Organization, established in 1919 at Basel, Switzerland, as a function of the League of Nations. Testimony during the recent Senate Committee hearings in Washington elicited the information that a major portion of the Wagner–Murray–Dingell Bills (S. 1606—H. R. 4730) was written by Isidore Falk, United States delegate to the I. L. O. and Director of Research and Statistics for the Social Security Board.

Congressman's Testimony

Congressman Arthur L. Miller, of Nebraska, a practicing physician of long experience, testifying regarding the distortion of draft rejection statistics, reminded the Senate Committee that the United States has the finest hospitals, and the most highly developed medical and surgical techniques in the world. He warned that the complete revolution of medical practice, medical education, hospitals and research under a federally-administered Compulsory Health Insurance Program would bring about progressive deterioration and ultimate collapse of the great gains medicine has made under the American free enterprise system.

Brower, Kleinschmidt Join AMA Council on Medical Service

The Council on Medical Service of the American Medical Association has two newcomers on its staff, Mr. Howard Brower and Mr. L. S. Kleinschmidt, according to a recent report from the Council.

Mr. Brower, who has been discharged recently from military service, is assisting in the Division of Prepayment Medical Care Plans. He has had insurance experience, serving for six years with the insurance department of the state of Michigan, and as a member of the staff of a private insurance company.

Mr. Kleinschmidt will pay particular attention to the rural aspects of prepayment medical care programs. He has a background of 32 years' experience in dealing with the public and in developing organizations for meeting special rural problems. During the past ten years, he has worked with state medical societies and lay groups in developing for the Farm Security Administration medical service plans designed to improve local rural health.

MARCH OF DIMES DIRECTOR NAMED

BYRON B. CONWAY

Byron B. Conway, of Wisconsin Rapids, has been named Wisconsin State Chairman of the 1947 March of Dimes which takes place January 15–30, Basil O'Connor, president of the National Foundation for Infantile Paraylsis, has announced.

Prominent as an attorney with his own practice in Wisconsin Rapids, Mr. Conway has also served as a special attorney for the United States Department of Justice. He has been long active in welfare and fraternal organizations and this marks his sixth year as a March of Dimes state chairman.

Mr. O'Connor, in making known Mr. Conway's acceptance of the chairmanship, revealed that in coping with the 1946 outbreaks of infantile paralysis the National Foundation sent to its chapters in the field more than two and a-half million dollars in epidemic aid up through September.

HILL-BURTON ACT—

(Continued from page 1)

pital Council is composed of the Surgeon General, who serves as chairman, ex officio, and eight members appointed by the Federal Security Administrator. Four members are outstanding in health and hospital fields, and four are representatives of the consumers of hospital services.

Doctor Buerki Appointed to Council

Those members representing the hospital and health fields are: Dr. Albert W. Dent, president, Dillard University, New Orleans, La.; Very Reverend Monsignor John J. Bingham, director, Division of Health, Catholic Charities, New York City; Graham Davis, director of hospitals, Kellogg Foundation, Battle Creek, Mich.; and Robin C. Buerki, M. D., dean, Graduate School of Medicine, University of Pennsylvania, Philadelphia, Pa.

Council members representing the consumers of medical services include: Dr. Michael M. Davis, Committee for the Nation's Health, New York City; Honorable J. Melville Broughton, attorney-at-law, Raleigh, N. C.; Mrs. Evelyn Hicks, radio station WTMB, Birmingham, Ala.; and Mr. Clinton S. Golden, United Steel Workers of America, Pittsburgh, Pa.

Mr. Miller pointed out that the Federal Hospital Council is unique in that the Hospital Survey and Construction Act vests it with certain administrative functions. These include the approval of general regulations under which the program will operate—an unusual responsibility for a council of this type.

Advisory Committee Members

Members of the advisory committee will serve as consultants to the Surgeon General and the Federal Hospital Council, in the administration of the Hospital Survey and Construction Act. To obtain the benefit of as wide representation as possible on the advisory committee its membership will be extended as specific needs arise. With the approval of the Federal Security Administrator, Doctor Parran has issued invitations to serve on this committee to 24 persons active in organization activities. Among them are: Arthur Bachmeyer, M. D., director, University of Chicago Clinics and Hospitals, Chicago; Henry Southmayd, director, Hospital Activities, Commonwealth Fund, New York City; Victor Johnson, M. D., secretary, Council on Education and Hospitals, American Medical Association, Chicago; Joseph W. Fichter, master, Ohio State Grange, Columbus, Ohio; Ranson E. Aldrich, American Farm Bureau Federation, Cleveland, Miss.; Nelson Cruikshank, director, Social Insurance Activities, American Federation of Labor, Washington, D. C.; Rev. A. N. Schwitalla, president, Catholic Hospital Association, and editor, Hospital Progress, St. Louis, Mo.; Miss Erma Holtzhausen, director of Nursing Services, Vanderbilt University Hospital, Nashville, Tenn.; Howard L. Russell, director, American Public Welfare Association, Chicago; Franklin S. Crockett, M. D., chairman, Committee on Rural Medical Service, American Medical Association, Lafayette, Ind.; and Right Reverend Monsignor John O'Grady, secretary, National Conference of Catholic Charities, Washington, D. C.

"MARCH OF MEDICINE" CARRIED BY SEVEN MORE STATIONS

Madison, Wis., Oct. 10—Seven radio stations have been added to the list of those that broadcast The March of Medicine, radio health program, it was announced by the radio department of the State Medical Society today. Of the seven, four, radio stations WRNJ, Racine; WHBL, Sheboygan; KFIZ, Fond du Lac; and WOSH, Oshkosh, are already broadcasting the programs once a week. The additions bring to a total of 23 the number of stations carrying the series.

Station WIKB, Iron Mountain, Mich., will begin operations soon, with a Wisconsin audience as well as Michigan listeners. It is part of the Upper Michigan-Wisconsin Broadcasting Company, Inc., of which the other two member stations, WJMS, Ironwood, and WATW, Ashland, have carried The March of Medicine programs for over a year and a half.

In addition, two new radio stations, recently completed, WSBR, Superior, and WDLB, Marshfield, will start carrying the series soon. The station at Superior will be managed by the personnel who were formerly associated with station WDSM in that city. It will operate under power of 250 watts, and be affiliated with the Mutual Broadcasting System.

Station WDLB at Marshfield, operating under 250 watts power, is managed by Mr. George Meyer who owns and directs the Medford radio station and is business manager of the Medford Clinic. Among the owners of the new station—Dairyland's Broadcasting Service—are Drs. L. A. Copps and K. H. Doege, both of Marshfield, and Mr. Meyer.

THE MARCH OF MEDICINE

SCHEDULE

Appleton	WHBY	Saturday	11:15 a. m.
Ashland	WATW	Saturday	8:30 a. m.
Eau Claire	WEAU	Tuesday	2:30 p. m.
Fond du Lac	KFIZ	Saturday	8:30 a. m.
Green Bay	WTAQ	Friday	1:45 p. m.
Iron Mountain, Mich.	WIKB	*Saturday	8:30 a. m.
Ironwood, Mich.	WJMS	Saturday	8:30 a. m.
La Crosse	WKBH	Thursday	4:00 p. m.
Madison	WIBA	Saturday	10:00 a. m.
Manitowoc	WOMT	Saturday	8:45 a. m.
Marinette	WMAM	Saturday	4:30 p. m.
Marshfield	WDLB	*	
Medford	WIGM	Friday	11:15 a. m.
Milwaukee	WEMP	Saturday	11:30 a. m.
Oshkosh	WOSH	‡Saturday	10:15 a. m.
Racine	WRJN	Sunday	2:30 p. m.
Rice Lake	WJMC	Monday	3:30 p. m.
Sheboygan	WHBL	Monday	9:15 p. m.
Stevens Point	WLBL	Monday	11:30 a. m.
Superior	WSBR	*	

* To begin operation soon.
‡ Alternate Saturdays.

VA BUYS LAND FOR NEW HOSPITAL IN MADISON

Agency Plans Construction of 500-Bed Institution

Washington, D. C.—The Veterans Administration has acquired 24 acres of land within a mile of the University of Wisconsin Medical School and Hospital, Madison, for the construction of a 500-bed tuberculosis hospital, the VA has announced.

The site, at the northwestern city limits, near the Forest Products Laboratory, is within two and one-half miles of other large Madison hospitals.

President Truman and the federal board of hospitalization approved the acquisition of the land, purchased by the VA from Harold C. Bradley, professor of physiological chemistry at the University of Wisconsin, Mrs. Keys Winterble, and the University.

President Truman also has approved acquisition of land for four other new Veterans Administration hospitals at Toledo, Ohio; New Orleans, Louisiana; Dallas, Texas; and Klamath Falls, Oregon, the transfer of two surplus military hospitals at San Patricio, Puerto Rico, and Baer Field, Fort Wayne, Indiana, to the VA for temporary use, and major changes in the VA hospital construction programs in Oklahoma and Missouri.

AMERICAN HOSPITAL ASSOC. FORMS NEW DEPARTMENT

Chicago.—The American Hospital Association has established a department within the association for the purpose of continuing certain of the functions initiated by the Commission on Hospital Care, as the commission disbanded Oct. 1, the association reports.

In cooperation with the United States Public Health Service, the association will continue to code and tabulate hospital schedules for state survey commissions through the Chicago office of the association, with the work done in accordance with methods acceptable to the U. S. P. H. S.

Application to the W. K. Kellogg Foundation and the National Foundation for Infantile Paralysis for grants of $10,000 per year for two years from each foundation was authorized by the Board of Trus-

(Continued on page 8, column 3)

Be Alert When Considering New Security Programs, Senator Urges

"The medical profession today faces one of its crucial tests, but it does not face this test alone. The public itself has a more vital stake in the problems confronting us in the field of public health and social problems," declared Senator B. B. Hickenlooper of Iowa in an address presented before the 95th Annual Session, Iowa State Medical Society, in Des Moines, April 18 and 19, 1946.

The Senator contended that the public more than the professional people as individuals, will feel most the affect of new programs, benefiting from a "free, stimulated, and progressive approach to sickness and health," or suffering from the restrictions of "regimented and circumscribed medicine."

During the time of war and the postwar era, the restlessness of the nation and release of tension causes confusion of problems, both social and economic, Senator Hickenlooper pointed out. Amid the confusion ideas formulate readily in large volume and experiments begin. Often, however, in a hectic period, many solutions apparently plausible, are adopted and carried out without beforehand consideration they result in nothing. "In such circumstances we are often led to accept the tinsel for the gold," the Senator asserted, and to find, when the glittering stage settings are taken away, there remains nothing of the illusion they created."

Freedom and Security Are Often Confused

Declaring that in thinking of social security, there is often the inclination to confuse security and freedom—two words and conditions that are not synonymous, Senator Hickenlooper gave as an example slavery, where the master provides the physical necessities of existence, such as food and shelter. The slave has security, but independence is gone; he has no freedom; incentive for personal improvement is eliminated.

"As paternalistic governmental security increases in scope and extends itself to more and more segments of our society, those segments in turn give up their latitude of action and freedom of choice, and much of the incentive which stimulates people to assume their own responsibilities, "The Senator emphasized saying, "Government paternalism means government dictation and rule; it means government control; and, as it extends its scope, the control and regimentation extend and the individual finds himself accepting paternalism in more and more fields of his normal freedom and being hedged about in proportion by rote, rule, and regulation which he has come to lean upon."

Impressive language is being used now in these postwar years to promote programs in this country supporting paternalistic controls by the government, urging that all parts and phases of our lives be governed by one body in Washington, and eliminating freedom from our existence, the Senator related, and concluded a section of his speech stating, "We are in the very midst of such a period now, and only the calm and sensible consideration by the public, in its own interest, will secure the adoption of sound and progressive laws and policies affecting the public interest and eliminate the programs which will, in fact, be destructive of the very freedoms and responsibilities which have made America great and which must be retained if America is to stay great."

Cancer Control is a Major Health Problem in U.S., Committee States

Cancer control is a major health problem in the United States, according to a statement from the joint committee on health problems in education, National Education Association and American Medical Association. As such, it merits attention not only in programs of research, but also in programs of education.

Instruction concerning the nature of cancer and known methods of prevention and control should be included in the high school course of study, along with other important health problems facing the American people today, the committee statement continued. High school students are interested in such information. Scientific facts should be taught to them so that fears may be allayed, intelligent action as future adults be promoted, and families favorably influenced by the information which students relay to adult relatives.

FISHING—CURE FOR "FRAYED NERVES"—?

Quoting part of a State Medical Society health news release and commenting upon it, the *Monroe Times*, daily newspaper published in Monroe, Wisconsin, printed the following article in the columns of its September 16 issue:

Waste of Energy?*

Our mail brings this under Madison dateline:

"There are several weeks of good fishing ahead and the State Medical Society reminds Wisconites that this sport is an excellent palliative for frayed nerves, tired bodies and weary brains. Absence of jangling telephones, crowded schedules and the miscellaneous irritations of business life coupled with the fresh air, warm sun and restful laziness of a few hours or days of fishing reduce worry and cares to the problem of landing the fish that are hooked.

"Whether fishing from the water's edge with a cane pole or from a boat in one of this state's lovely lakes with a fancy rod and reel, most people return refreshed and invigorated; their appetites are improved and they sleep better. Even if the catch doesn't add materially to the larder, a fishing expedition usually brings beneficial results so far as health and spirts are concerned.

"If you're using a boat, remember to examine it carefully before setting forth; don't overload it and keep your eye on the weather, because many Wisconsin lakes are shallow and become very rough quickly when there is a storm."

We rather dislike having to remind the state medical society, in return. every year about this time that we do not like to fish and the society may as well save its stationery. We don't even mind joining the Rod and Gun club—which. incidentally, hasn't been around yet to collect a fee from us—but in all our experience no wall-eyed pike, muskellunge or even a fingerling perch has attacked us. We intend to keep the score even.

Many's the time we have noted the fellow returning from a fishing trip "refreshed and invigorated," with appetite improved and fully caught up on his sleep. That's a laugh. Most of them need another 2-week vacation to attain anything like refreshment and the only time they might have slept on those vacation trips they spent playing stud poker. As for appetite, that's the one thing we have had most of in a long and varied career of diversified endeavor.

We rather like that line about "frayed nerves, tired bodies and weary brains." Quickest way to develop all three symptoms is to awaken at 4 in the morning to run the trot lines, get breakfast in a dirty skillet at 6 a. m., spend the morning pulling the oars to a favorite fishing spot — where it develops, there are nothing more than turtles, and a wily eel—spend the afternoon pulling the oars back to camp, wearily prepare an evening meal, relax over bottle and deck of cards until 2 a. m., go out to set the trot lines, and then pile in the covers for at least a full hour of sleep.

Do we seem irritable about all this? Well, you see, we haven't had ours yet and we have "frayed nerves, tired body and weary brains" listening to the rest of the force tell about theirs.

Know what we're going to do? Set forth for the north. Where are we going? Fishing in the north country. Hand down that bottle of aspirin.

* Reprinted in full from the *Monroe Times*, Sept. 16, 1946.

HOSPITAL ASSOC.—

(Continued from page 7)

tees of the association and these grants have been approved. The funds will be used by the American Hospital Association in conjunction with personnel supplied by the U. S. P. H. S. The Commonwealth Fund will finance the publication of the Report of the Commission on Hospital Care.

Dr. Llewellyn R. Cole, well known to University of Wisconsin students as director of the student infirmary for many years, has recently been transferred to the new position of coordinator of graduate medical education, but will still continue his duties as professor clinical medicine.

Dr. John Bentley, associate professor of clinical medicine, will take over the directorship of the University Infirmary.

The
MEDICAL FORUM

The Wisconsin Medical Journal November, 1946

HOUSE ADOPTS MAJORITY REPORT ON MEDICAL CARE

DR. JUNG JOINS STAFF OF COUNCIL ON PHARMACY AND CHEMISTRY, AMA

Dr. Frederic T. Jung, formerly of Sheboygan, a member of the teaching staff of Northwestern University Medical School for the past 20 years, has recently joined the headquarters staff of the Council on Pharmacy and Chemistry of the American Medical Association. He is serving as assistant to Dr. Austin E. Smith, secretary of the council.

Doctor Jung's experience and training is being applied to various phases of the council's work, Doctor Smith reports. The council's principal objective is to inform the medical profession and the public of advances in the use of drugs. The 18-man council, organized in 1905, also leads campaigns against dangerous drugs.

After graduating from the University of Wisconsin and the University of Chicago, Doctor Jung received his M. D. degree from Northwestern University Medical School, Chicago. He served his internship at Norwegian American Hospital, Chicago.

Dr. Middleton Attends Washington Conference

Washington, D. C., Oct. 15—Dr. William S. Middleton, dean of the medical school and professor of medicine, University of Wisconsin Medical School, Madison, was among the physicians who attended the first conference of the Medical Advisory Committee to the Secretary of War, September 18, the Office of the Surgeon General announced today.

The committee, recently appointed by the Honorable Robert P. Patterson, and of which Doctor Middleton is a member, met in The Pentagon to discuss problems in postwar Army medicine.

Drs. C. O. Vingom, Dexter H. Witte Present Majority and Minority Reports

Convening October 9 at the Annual Meeting in Milwaukee, the House of Delegates of the State Medical Society considered the majority report given by Dr. C. O. Vingom, Madison, and the minority report, the opinions of the three Milwaukee members presented by Dr. Dexter H. Witte, Milwaukee, of the Special Committee on Prepaid Medical Care that was designated on June 22 by the House of Delegates to prepare a state-wide program of medical care of the character of Surgical Care and to arrange for absorption of Surgical Care of Milwaukee County.

By a vote of 55 to 14 the House of Delegates adopted the majority report with an amendment by Dr. J. W. Truitt, Milwaukee, which was adopted and incorporated in the resolution. The resolution as finally adopted follows in full:

State Medical Society Resolution of House of Delegates Relating to Wisconsin Physicians Service

WHEREAS, the House of Delegates of the State Medical Society of Wisconsin in special session assembled on June 22, 1946, in recognition of its sustained interest in and its sense of professional responsibility for ever higher standards of public health did by resolution create a special committee of nine "to arrange the establishment of a state-wide prepaid medical care organization of the character of Surgical Care, this committee to arrange for the absorption of Surgical Care of Milwaukee County at the earliest feasible time," and

WHEREAS, pursuant to such resolution a special committee was appointed and organized, and after careful consideration it has prepared and filed with the members of this House its Report and Recommendations covering first, a proposal for establishment of a state-wide prepaid physicians service, and, second, a proposal for absorption of the Surgical Care plan of The Medical Society of Milwaukee County, and

WHEREAS, it is the sense of this House after individual study and careful deliberative consideration by this body of the two-fold proposal of its special committee, that the Report and Recommendations of such committee should be adopted as representing a sound, workable plan which is in the best health interests of the residents of this state, and which plan is at the same time designed in compliance with the charter law of this Society, with applicable insurance statutes and with sound fiscal and actuarial principles,

Be it therefore resolved that:

1. There is established as an agency of this Society the Wisconsin Physicians Service.

2. The effective date for the operation of the plan of Wisconsin Physicians Service shall be December 1, 1946.

3. The details of the Wisconsin Physicians Service plan shall be as set out in the Recommendations of the Special Committee of the House of Delegates for Prepaid Medical Care Plans, which Recommendations are herewith incorporated by reference, except where fully set out.

4. Operation of Wisconsin Physicians Service shall be under the direction of an Operating Committee of nine members of the State Medical Society, this committee to have the following geographical distribution: Three from Milwaukee County, one from Racine or Kenosha Counties; five from the remainder of the state, not more than two of said five to come from any one county. The Operating

(Continued on pages 6 and 7)

Rural Areas Receive Help in Health Plans From State Medical Societies

Journal of the A. M. A. Reports That Rural Health Programs Include Enrolment in Prepaid Medical Care Plans

Receiving aid and guidance from state medical societies, various rural and farm organizations throughout the country are improving their communities by initiating health educational programs and enrolment in prepaid medical care plans on a local basis, according to an editorial in the November 2 issue of *The Journal of the American Medical Association.* The editorial states:

"The Committee on Rural Medical Service of the American Medical Association at its meeting in San Francisco on June 30 reported that 31 state medical societies had made progress toward establishing rural health committees and formulating medical society sponsored plans to improve rural health and to provide for voluntary prepayment against costs of illness. The Council on Medical Service and the Rural Medical Service Committee held additional meetings in September, emphasizing the interest of the medical profession in leading movements to improve the health services of rural communities. Significantly, committees formed by various rural organizations in the states to develop plans for health services have been interested in the point of view of the medical profession; leaders of national farm organizations are seeking the guidance of medical agencies. The major farm organizations are cooperating in the development of rural health programs. Through their committees they are initiating health educational programs and enrolment in prepayment plans on a local basis.

"Joint meetings of rural health service committees of state medical societies and committees on rural health service of farm organizations have been reported by several states and are being planned by others. The discussions center around farm health needs, health facility surveys, medical personnel, an adequate public health and sanitation program, health education in the schools, dental health needs, health legislation, hospitals as memorials to war heroes and what has been done for rural medical care in other states. Minimum standards for each type of health service need are being considered by state and national committees to serve as a guide, not to tell the local people what to do but to point out a way in which it may be done when once a decision has been reached.

The Committee on Public Policy of the State Medical Society of Wisconsin, recognizing "that there are scattered areas of population within which the services of a physician are not readily available," offered a suggestion for better distribution of physicians between rural and urban areas of the state in its report to the House of Delegates of the SMS. The House, convening during the Annual Meeting in Milwaukee, on October 8 approved the report containing the following suggestion of the committee "that the Society urge upon the legislation an appropriation of $20,000 annually to be spent by the State Board of Health in appointing physicians in necessitous areas as deputy state health officers, upon determination by the Board as to the areas in need . . . such physicians might, by relatively modest sums, be compensated for the basic initial costs involved in establishing and maintaining office facilities in areas needing them, during the period in which a practice is being developed."

"The report from the physicians' rural health service committee of Minnesota states that 'if the presence of a physician in the community is to have the full effect in rural medicine, we must also have suitable homes for our rural families, balanced diet for the promotion of healthy growth and the maintenance of vigorous bodies. Knowledge of good living habits, instructions for expectant mothers, infant care, the home management of common ailments and first aid are most important and full confidence in and proper utilization of facilities for hospital and medical care that are at hand.'

"From Indiana comes the suggestion that hospitals might be extended into rural areas by inviting physicians in villages around hospitals to the courtesy staff. Thus they could attend staff meetings, bring their patients for consultation or diagnosis and care for their patients within the limits of their experience.

"The problem of the farm family with low income in obtaining and paying for medical care might be solved by securing enrolment of farmers in a prepayment plan when income is relatively high. In some areas state and local welfare agencies may prepay the premiums of the indigent, and the state and local taxing units may be approached for part of the premium for low-income families."

MEDICAL PROGRESS HAMPERED BY ANTI-VIVISECTION, STATES U. S. CHAMBER OF COMMERCE

Chicago — Research on animals for the development of life-saving medical knowledge has been endorsed by the Chamber of Commerce of the United States in a statement of policy released recently by Howard Strong, secretary of the Health Advisory Council of the Chamber of Commerce.

Mr. Strong announced the policy as the result of a referendum vote of member organizations. The statement submitted for the vote is as follows: "In view of the great progress that has been made in preventive and curative medicine and surgery through animal research and the prospect of even greater progress in the future, the National Chamber is unalterably opposed to the prohibition of this scientific procedure. Such a prohibition would seriously hamper all medical progress."

Vote Statistics

Result of the vote was: 2,424 organizations in favor of the statement, 18 against. Represented in the poll were slightly over a million business men.

Mr. Strong, in a letter to Dr. A. J. Carlson, president of the National Society for Medical Research, announced the outcome of the Chamber of Commerce referendum and said, "We are therefore now in a position to present the Chamber's opposition to any anti-vivisection legislation wherever such legislation rears its head and when advisable and possible, a representative of the Chamber can appear in opposition."

EMPLOYER-FINANCED UNION-OPERATED HEALTH PLAN OFFERS VARIED BENEFITS

Such a Plan Not Considered Insurance Business By One Attorney General

In recent years the International Ladies' Garment Workers (AFL) and the Amalgamated Clothing Workers (CIO), among other unions, have established union-operated and union-administered health and vacation programs, with a fund paid for by the employers. The employers pay for the fund from a 3½ per cent tax on gross weekly pay rolls, and a union health center is maintained with the fund.

The operation of such a union health plan apparently is not considered engaging in the insurance business as judged by the opinion of one Attorney General. Ohio's Attorney General Hugh S. Jenkins' opinion on accident and health companies says: "Where the bargaining authority of a number of local unions enters into a contract with various employers employing members of the union governing hours, wages and working conditions, and also providing that the employers contribute an amount equal to 4 per cent of the weekly payroll of all workers into a fund known as 'The Health Insurance Fund' for the benefit of members and for the following objectives: (1) the establishment of a sick benefit fund; (2) the establishment of a plan to secure medical advice; (3) the distribution of funds as a contribution toward vacation benefits; and (4) some plan of group insurance, and also providing that the management and ownership of the fund are to be in a Board of Trustees appointed by the union and the employers and where the employes make no contributions to the fund, said transaction does not amount to engaging in an insurance business."

Benefits Available Under Plan

With the employer-paid, union-directed health plan, varied and extensive medical care is available to the worker at no cost to him. Under the ILGWU health plan, a worker's membership card entitles him to benefits for sickness, annual medical care, including examination and treatment prescribed by the union health center physician, hospitalization, maternity care, tuberculosis, free eyeglasses and eye examinations when necessary, and a paid vacation of a week (for a member working in the industry for a year or more).

Operation of the health program is directed by the union through a health fund committee whose trustees are officers of the dressmakers' joint board. The committee is responsible to a health fund council, an equally divided union-industry group, presided over by the industry's impartial chairman.

COMMITTEE ON INDUSTRIAL HEALTH TO REVISE ORDERS FOR INDUSTRIAL NURSES

Nov. 2—As one of its projects for the current year, the Committee on Industrial Health, in cooperation with the Industrial Hygiene Unit of the State Board of Health is planning to revise the standing orders for nurses in industry issued by the State Medical Society a number of years ago, Dr. D. E. Dorchester, chairman, announced recently.

The basic standing orders will be revised in keeping with standards set by the American Medical Association, with supplemental material covering the special fields of surgery, internal medicine, dermatology, and EENT. For the specialty standing orders the committee will be assisted by a special committee appointed by Dr. P. R. Minahan shortly before the Annual Meeting. The committee assisting the Committee on Industrial Health consists of Drs. Thomas Burdon, Green Bay, O. A. Sander, Milwaukee, and John T. Sprague and M. J. Reuter, Milwaukee.

In order to determine the extent and nature of industrial practice in the state, the Committee on Industrial Health is conducting a survey among all members of the State Medical Society and the Wisconsin Manufacturers Association, on which the future activities of the committee will be based.

It is anticipated that during the next six months the Committee on Industrial Health will conduct a series of in-plant medical clinics. The details will be announced in a later issue of the *Journal.*

THREE BLUE CROSS PLANS RAISE RATES

Chicago, Ill.—Three separate Blue Cross Plans recently announced substantial rate increases, according to a report from the Health and Accident Underwriters Conference.

In the Chicago area, the family rate for direct payment subscribers jumped from $6.75 to $9.75 per quarter. Effective December 1, the St. Louis Plan will charge $1.00 per month for individuals and $2.00 for all families. Their present rates are 75 cents per month for individuals; $1.25 for an employee and one dependent; and $1.50 for an employee and two or more dependents. The Hospital Service of Iowa rates were raised 20 per cent.

RUSH

Your patient is often our policyholder. When he presents you with one of our claim blanks, you will be helping him tremendously by completing it immediately.

Our claim blanks are intended to be simple, because your answers to our questions are important to prompt payment of claims. Please, doctor, don't delay those claim reports, and thanks.

(If you have any ideas as to how our claim reports could be made more clear—we're listening!)

The Time

Insurance Company

213 W. Wisconsin Ave.

Milwaukee 3, Wis.

NORTH CENTRAL MEDICAL CONFERENCE HOLDS ANNUAL MEETING IN ST. PAUL

St. Paul, Minn.—Coordinated with a regional meeting of the Council on Medical Service of the American Medical Association, the North Central Medical Conference annual meeting is being held November 10 at the Hotel Saint Paul in St. Paul.

Doctor McCarthy Presides

With J. D. McCarthy, M. D., of Omaha, Nebraska, president of the conference presiding, morning and afternoon sessions of speeches and general discussions are scheduled. A presidential address, "The American Medical Association as an Instrument to Advance the Ideals of American Medicine," by Doctor McCarthy, starts the program that includes among other speakers, Dr. George F. Lull, secretary and general manager of the A. M. A.; Dr. L. W. Larson, Committee on Rural Medical Service, A. M. A.; Dr. E. J. McCormick, chairman of the Council on Medical Service, A. M. A.; Dr. A. W. Adson, member of the Council on Medical Service; and Mr. Thomas A. Hendricks, secretary of the Council on Medical Service.

WM. L. COFFEY ELECTED A TRUSTEE OF AMERICAN HOSPITAL ASSOCIATION

Gathering in Philadelphia recently for an annual meeting, members of the American Hospital Association elected Mr. William L. Coffey, director of the Milwaukee county institutions, as one of the nine members of its board of trustees.

Mr. Coffey, whose election was urged by the Wisconsin Hospital Association, has served as director of the institutions of Milwaukee county since 1921. During the depression of the early 30's the President of the United States appointed Mr. Coffey, on a voluntary basis, Civil Works Administrator for the State of Wisconsin. Later he was appointed Federal Emergency Relief Administrator for the state. Mr. Coffey has served as a director of the Wisconsin Hospital Association for several years, including a term as its president.

Pharmacists Work With VA Furnishing Physician-Prescribed Drugs For Veterans

Washington, D. C., Oct. 19—Pharmacists in 44 states and in the District of Columbia are cooperating with the Veterans Administration to furnish drugs prescribed by local physicians for veterans with service-connected disabilities, Dr. Paul R. Hawley, chief of VA's medical service, announced today. Wisconsin is one of the states working with the VA through its pharmacists.

Milwaukee — "The Wisconsin Pharmaceutical Association's agreement with the Veterans Administration to furnish pharmaceutical service has been in operation since August," Mr. Jennings Murphy, secretary of the Wisconsin Pharmaceutical Association, states, adding, "Approximately 60 per cent of our members have signed agreements with our Association to participate in this plan."

"Our association has completed its plan for checking and pricing of prescriptions and medical requisites. Under our agreement we can only pay pharmacists for the following medical requisites: Insulin syringe and two needles, two hypodermic (insulin type) needles, atomizer, nebulizer, hot water bottle, fountain syringe, combination hot water bottle and syringe, ice bag, ice cap, urinal, bed pan, enema can, feeding tube, ear and ulcer syringe, gauze, bandages, and adhesive tape."

"VA prescriptions from all over the state are coming into our office each day," Mr. Murphy reports, "and it appears that the plan will grow each month as more physicians participate."

To be eligible for the service, veterans must receive prescriptions from private physicians operating under VA's home-town medical care program or from VA-designated or fee basis physicians. In either case, veterans must be receiving medical treatment for a service-incurred illness or disability.

This service is the result of contracts made by the VA with state pharmaceutical associations. Fees charged by pharmacies operating under the plan are approximately equivalent to averages fees for prescriptions charged the general public.

In addition to drugs, certain specified "medical requisites," such as insulin syringes and needles, atomizers, nebulizers, hot water bottles, fountain syringes, ice bags, and feeding tubes are available under the plan. These items are to be prescribed only in cases of emergency.

Board of Medical Examiners Institutes Court Action Against Three Physicians

River Falls, Wis., Oct. 16—Three cases concerning physicians that are pending in Wisconsin courts, are reported by Kenneth S. White, attorney for the State Board of Medical Examiners. They are as follows:

Dr. G. W. Rastede, an osteopathic physician and surgeon of Hudson, Wis., was arrested recently charged with having produced a miscarriage in violation of section 351.22, Wisconsin Statutes. Information upon which the complaint against Doctor Rastede was based was furnished to the district attorney of St. Croix County by the Wisconsin State Board of Medical Examiners.

An action has been commenced by Mr. Andy Borg, district attorney for Douglas County, at the request of the Wisconsin State Board of Medical Examiners, against Dr. Marvin S. Averbook, M. D. formerly of Superior, for the purpose of revoking or suspending his license to practice in this state. Doctor Averbook now resides in California, but it is alleged in the complaint against him that prior to leaving Superior he performed an illegal abortion.

At the request of the Wisconsin State Board of Medical Examiners, the district attorney of Adams County has commenced an action against Dr. Glenn F. Treadwell of Friendship. Doctor Treadwell was convicted in Federal Court of two violations of the Federal Narcotic Act and the complaint against him in the State Court asks that his license be revoked or suspended on the basis of his conviction in Federal Court.

Doran Reports Progress of Veterans Medical Service Agency Participation Plan

Madison, Wis., Nov. 4—Of the enrolment cards that were sent to all members of the State Medical Society September 30, to be signed by physicians interested in treating veterans through the Veterans Medical Service Agency, 1,544 have been signed and returned, according to a report from Mr. Thomas J. Doran, director of the agency that began operation November 2.

The physicians who signed the cards, indicating participation in the program, will be supplied with the proper forms to be used in requesting authority to treat the veterans. Sample copies of the forms (no. 100) are now being forwarded to these doctors along with the blank forms and an instruction sheet to assist the physicians in filling out the forms. Form 100 is not an authority itself, but a means of obtaining authority to treat a patient under the program.

Agency to Act for the MDs

The Veterans Medical Service Agency will act for the doctors in securing authorization and in collecting the doctors' bills from the authorizing governmental unit. The agency is set up as a central unit to speed up the receipt of authority from the two cooperating

(Continued on page 6, column 1)

MDs Request Parking Space Near Offices

Watertown—"The request made to the city council by 16 local (Watertown) physicians that some provision be made to provide parking space on streets close to their offices is understandable, and is not unreasonable," the *Watertown Times* commented editorially in its October 25 issue, urging the council of the city to provide such parking space for physicians.

Emergency calls necessitate counting time to the second; walking several blocks to a car may cause the doctor to lose too many valuable seconds and minutes. And the editorial further states: "They (the physicians) are not asking for it as a convenience for themselves. They are seeking this consideration in order that they may be of the greatest possible service to the people of this community."

Five Cooperative Insurance Companies In the Northwest Show Large Gains

The total combined premium income of the five unified cooperative insurance companies in the Northwest should reach about $2,000,000 at the close of 1946, if the rate started the first half of the year continues, F. F. Rondeau, general manager, reported at the quarterly board meeting in August at Superior.

Combined Assets

Combined assets of American Farmers Mutual in Minnesota and of Cooperative Insurance Mutual in Wisconsin amounted to $1,657,199 on June 30, 1946, the directors were told, nearly a 30 per cent increase over the same period of 1945. Combined premium income of the two firms to June 30, was $817,838—a 72 per cent jump over last year, with 33,502 new auto insurance coverages written to June 30.

The two insurance firms, Cooperators Life Association, Minnesota, and Cooperators Life Mutual, Wisconsin, had combined assets on June 30, of $449,962, which is 28 per cent greater than the same time last year. Premium income is up 31 per cent. A total of $2,006,350 of individual life insurance coverage was written in both states to June 30—a 187 per cent jump over last year.

Central Mutual Fire had total assets on June 30 of $64,437, an 18 per cent rise. Premium income jumped 82 per cent, and total fire insurance coverage written to June 30 was $9,911,749—108 per cent greater than the same time last year.

The five companies had combined assets totaling $2,171,598 on June 30—a 29 per cent increase. Total combined premium income of $997,452 is 65 per cent greater than for same time last year.

At the meeting the directors approved a recommendation of management that the companies continue to invest part of their funds in direct consumer home loans at 4 per cent interest.

Accidents, Cause of Rate Rise

If fewer drivers were involved in accidents, auto insurance rates would not be on the rise, Rondeau commented. He reported that publicity for safe driving is being issued in an attempt to teach motorists that careless driving does not pay.

NEWS OF PREPAYMENT MEDICAL CARE PLANS

from the Council on Medical Service, American Medical Assn.

DISTRICT OF COLUMBIA: "Medical Service of the District of Columbia" has been completed and will now offer a prepayment plan in the Capitol. Twenty incorporators have been selected for the service. The plan will be a "service plan" for single persons earning $2,500 and for families with a $4,500 income per year. The scheduled monthly dues are 75 cents for the individual, $1.50 for a man and wife and $1.74 for a family.

ARIZONA: The House of Delegates of the Arizona State Medical Association approved a medical service plan for the people of the State of Arizona. The plan provides for surgical and obstetrical care for group insured hospital patients. It also provides care for fractures both in and out of the hospital. The service covers the employee and his family and unmarried dependents under nineteen years of age.

MONTANA: One of the increasing number of new plans to commence operation has announced that enrolment started as of August 1. Over 70 per cent of the membership of the Montana Medical Association are participating physicians. In the first two months, over 5,000 subscribers have joined the plan.

IDAHO: The North Idaho Medical Service Bureau of Lewiston, Idaho, has been formed to provide a prepayment program for the northern part of the state. As of June 30 the enrolment was 2,227. The State Committee on Prepaid Medical Care has recommended that a state-wide plan be deferred for the present, awaiting the experience in north Idaho.

FRANK G. DICKINSON LEAVES U. OF ILL., JOINS AMA STAFF

Chicago, Oct. 18—Resigning his position as associate professor of economics at the University of Illinois, Frank G. Dickinson, Ph. D. has accepted the position of economist, and director of the Bureau of Medical Economic Research of the American Medical Association the A. M. A. announced today. He succeeds R. G. Leland, M. D., retired, who had served as director of Medical Economics since it was established in 1931.

Illinois Graduate of 1921

Except for one year at Pennsylvania State College where he received his M. A. degree, Doctor Dickinson has taught at Illinois since graduation in 1921. He obtained his Ph. D. degree at Illinois in 1927. He served as president of the American Association of University Teachers of Insurance during 1944 and 1945, and as its secretary-treasurer from 1932–1937, and was one of the joint authors of the preliminary draft of the Illinois Insurance Code in 1934–35. Doctor Dickinson is also a well-known pension and statistical consultant for corporations and is a contributor to scientific and popular journals.

He may be remembered through the Dickinson Football Ratings and the Rockne Memorial Trophy, sponsored by the famous Four Horsemen, which he permanently awarded to the University of Minnesota in 1940.

DORAN REPORTS—

(Continued from page 5)

agencies, the Veterans Administration and the State Department of Veterans Affairs. As soon as the agency secures authority from the VA or the State Department of Veterans Affairs, the doctor will receive Form 200 which is his actual authority to treat the individual and specifies the amount of money and the maximum period of time in which he can treat the veteran. As rapidly as the Veterans Medical Service Agency receives Form 200 information from the doctor it will proceed to collect the bills and reimburse the doctor for services rendered.

HOUSE ADOPTS REPORT—

(Continued from page 1)

Committee shall be vested with all powers necessary for the efficient operation of Wisconsin Physicians Service, subject to policies and instructions from time to time enunciated by this House. The Operating Committee shall be nominated by the incoming President by and with the consent of the House of Delegates. Each county medical society, not less than ten days before the first annual session of the House of Delegates, may recommend to the President nominees for each position on the Operating Committee to which that county may be entitled under the provisions of this paragraph. The President shall be required to make his nominations from recommendations so submitted by the Milwaukee, and the Racine and Kenosha County Medical Societies, but shall be unrestricted in other nominations. Following the appointment of the Operating Committee, the President shall designate one of its members as chairman. The terms of the Operating Committee shall be for three years; provided that not more than one member from a given county shall be chosen in a given year; provided further, that in 1946, three members shall be named for a term of one year, three for two years and three for three years, not more than one member from a given county to fall within any one of the three time groups in the initial or subsequent appointment.

5. The Council is hereby authorized to appropriate from time to time such sums as may be necessary for auditing, actuarial and legal services required for the establishment of Wisconsin Physicians Service, the purchase of equipment and furnishings, and for such further advances as may be required by organization of Wisconsin Physicians Service and the absorption of the Surgical Care Plan.

6. Funds of Wisconsin Physicians Service shall be separately maintained. All payments from Wisconsin Physicians Service funds shall be on vouchers only, and shall require a countersignature. The Operating Committee shall determine who is authorized to sign vouchers on said funds. Signatures may be inscribed on vouchers by special machine, under adequate bonding and other safeguards. No salary or other compensation shall at any time be paid, directly or indirectly, to any officer of the Society out of Wisconsin Physicians Service funds.

7. It is also the considered policy of this House that Wisconsin Physicians Service shall be operated as economically as is consistent with demonstrated public needs, sound medical practice, and established fiscal and actuarial principles. Consistent with these principles and with the service character of the plan of Wisconsin Physicians Service, it is understood that payments to participating physicians for services rendered under the plan shall be subject to such uniform adjustments in service benefits as may be necessitated from time to time by reduced income, high utilization, or other causes.

8. This House herewith rescinds, effective at 12:00 p. m. (midnight), Central Standard Time, November 30, 1946, the following paragraph of the resolution adopted by it at its special session of June 22, 1946.

> "4. This House of Delegates approve the 'manner of establishment' of the Surgical Care Plan of Milwaukee County."

9. All contracts, to which Surgical Care is a party may remain in effect until 12:00 p. m. (midnight), November 30, 1946, as of which time the House of Delegates shall discontinue in its entirety the experimental prepaid medical care plan designated as Surgical Care, an agency of The Medical Society of Milwaukee County, deriving its power to do so from the fact that Surgical Care has never been anything but an experimental plan permitted to operate by the State Medical Society under an arrangement by which the management was delegated to the Board of Directors of The Medical Society of Milwaukee County as a committee of the Council of the State Medical Society.

10. The Medical Society of Milwaukee County, through its Board of Directors acting on behalf of Surgical Care, shall transfer to Wisconsin Physicians Service all assets of Surgical Care as of the close of business, November 30, 1946, and Wisconsin Physicians Service shall liquidate all medical claims of Surgical Care arising prior to 12:00 p. m., Central Standard Time, November 30, 1946, under contracts executed in the name

(Continued on the next page)

of Surgical Care. Surgical Care is not entitled to receive or retain any unearned subscription or premium income accruing, payable or paid after 12:00 p. m., Central Standard Time, November 30, 1946, it being expressly understood that any unearned subscription or premium income which may have been paid to Surgical Care prior to such time, although not earned until after such time, shall be paid without special demand to Wisconsin Physicians Service as the successor agency. Surgical Care is directed to permit no contracts executed in its name or on its behalf to remain in effect after such date; unless by their terms it is impossible as a matter of law to effect a cancellation of them by such date. In the latter event, they are to be assumed without modification by Wisconsin Physicians Service, as the successor agency, as to claims arising after such assumption date.

11. The Medical Society of Milwaukee County, as a component of the State Medical Society of Wisconsin, is directed to turn over to the secretary of the Operating Committee of Wisconsin Physicians Service, or to any designated enrolling and billing agency of the latter, a full list of groups and of individual subscribers within such groups, together with effective and expiration dates, if any, this information to be furnished immediately following the October, 1946, session of this House, so that proper representations may be made to all policyholders of Surgical Care respecting Wisconsin Physicians Service, the new agency which will continue medical and surgical coverage in force for such policyholders, as of 12:01 a. m., Central Standard Time, December 1, 1946.

Operating Committee

The Operating Committee of Wisconsin Physicians Service had its first meeting on October 23, and selected Dr. C. O. Vingom, Madison, chairman; Dr. A. T. Nadeau, Marinette, vice-chairman; Dr. L. V. Littig, Madison, treasurer; and Mr. Ralph Weber, acting director.

The subscriber contract was finally approved and offers surgical service, medical service for 10 days after the first three days in the hospital, anesthesia and maternity service, and adds an additional feature of diagnostic x-ray service performed outside a hospital immediately preceding surgery or in connection with fractures and dislocation reduction of not in excess of a value of $10. It also includes emergency surgical services not requiring bed care but rendered in a regularly accredited hospital during the first 24 hours following accidental injury.

Under Wisconsin Physicians Service, full protection is available to an unmarried subscriber who is a member of an employed group and whose annual income does not exceed $2,000, or to a married subscriber, a member of an employed group, whose family annual income does not exceed $3,600. The individual rate is 90 cents a month, and the family contract is $2.50 per month.

An agency contract has been offered the Associated Hospital Service, Inc., of Milwaukee (Wisconsin Blue Cross) to act as enrolling and billing agent for Wisconsin Physicians Service which will begin operation December 1, 1946.

Health Departments and Hospitals Should Cooperate, Commission Urges

Commission on Hospital Care Says Mutual Benefits Would Evolve

Cooperation between hospitals and public health agencies, curative programs and preventive medicine, is lacking, according to a report from the Commission on Hospital Care, a non-government public service committee to study hospital service in the United States.

The division of medicine into the two sections, preventive and curative, has been the main influence that has separated health departments and hospitals. The health department was considered to function to prevent disease through enforcement of laws and regulations designed to protect the mass of the people; the hospital was to concentrate on the diagnosis and treatment of the individual patient and providing the necessary facilities for the medical profession to do so.

The discovery of the bacterial cause of many diseases recently has led to knowledge of prevention of the diseases. Campaigns against infectious diseases such as syphilis and tuberculosis have shown the need for a closer relationship between the two divisions of medicine, for the mass approach of the health department cannot control those diseases alone. As the Commission on Hospital Care reports, "The discovery of individuals afflicted with these diseases and their treatment has become a public health method of attack. If the health department is to meet its responsibility of protecting the community's health, it has to consider more and more the individual's health status. As always, it needs the cooperation of the medical profession and logically it ought to be assisted in attaining this through a closer relationship with the hospital where the physician spends a considerable portion of his time practicing his profession."

Cooperation Eliminates Duplication

The commission believes that closer relationships should be established in personnel and facilities, and integrated action programs developed. Cooperation would eliminate duplication of effort and facilities. The ideal arrangement, the commission says in its Hospital Survey News Letter, is that the health department be situated in or near a hospital, permitting for convenience of a joint laboratory. Use of the laboratory by both health department and hospital personnel would enable

(Continued on page 8, column 2)

Christmas Seals

. . . Your Protection Against Tuberculosis

SIMULATION OF ILLNESS, PSYCHONEUROSIS OFTEN CONFUSED, MD SAYS

Ann Arbor, Mich.—Some physicians, lawyers, and insurance adjusters have a wholly unjustifiable habit of confusing the simulation of illness with psychoneurosis, Dr. Moses Keschner, faculty member of Columbia University College of Physicians and Surgeons, declares in an issue of the University of Michigan Law Review.

"They are two distinct and entirely different clinical entities", Doctor Keschner points out. "A psychoneurosis is an actual illness in which unconsciously developed symptoms of physical or mental disease offer to the patient a possibility of solving his inner conflicts and fear of loss of security." The malingerer, Doctor Keschner says, practices deception consciously with the prospect of financial gain or of deriving some other advantage.

"Both the reason for the symptoms and their development are not consciously understood by the psychoneurotic," the doctor says. "He tells the truth or what he believes to be true; he honestly believes that he is afflicted with the condition to which he attributes his alleged disability. In workman's compensation cases, it may be true that neither the malingerer nor the psychoneurotic wants to return to work, but the former is aware that he could go back to work if he chose, while the latter either is actually unable, because of his neurosis, to return to duty or honestly believes himself to be so."

Simulation Defined

Simulation may be defined as a wilful, deliberate, and fraudulent imitation or exaggerating of illness intended to deceive the observer for the purpose of gaining a consciously desired end, Doctor Kechner reports. Being conscious of the deception and fraud is the determining factor in what constitutes malingering, he points out.

Simulating a physical or mental disease is usually resorted to by the following groups, he points out: (1) by persons who have sustained an injury, with possible disability benefits or of collecting damages by charging negligence; (2) by persons desiring to collect insurance benefits for disability; (3) by those seeking to escape the draft or by "goldbrickers" in the armed services seeking to escape certain duties, and (4) by persons who wish to avoid some legal or other responsibility.

Doctor Keschner has the following advice on how to detect simulators. Most simulators are readily detected because they grossly exaggerate their "manufactured" symptoms. Unless he is "well tutored," a simulator resents examinations and will do anything to prevent them; he resists all efforts at cure. This is in marked contrast to the neurotic who requests repeated examinations and is eager to submit to any form of treatment. During the examination, a simulator avoids looking the examiner straight in the face; he resents being questioned, and his answers are either non-committal, hesitating, or absurd.

HEALTH DEPARTMENTS—

(Continued from page 7)

the laboratory to retain more competent workers as time and equipment would be more fully occupied.

The tuberculosis control program, an important work of the health department, requires x-ray equipment and experienced radiologists; both are available in hospitals. Joint use of such equipment would lower operation costs and benefit both groups. With maternal and child health too, care involves both the hospital and the health department. Preferable to the divided care offered maternity cases now—prenatal care at a health department clinic and delivery in a hospital—would be a clinic maintained at the hospital with full cooperation between the health department and attending physician. A clinic for ill infants and "well-baby" examinations conducted at the hospital too would "avoid duplication of effort and expense and better integrate the work of the hospital, the medical profession and the public health agency," the commission report continues.

The public health agency and hospital would mutually benefit also from cooperation on programs for the care of communicable disease, the development of better health education, social service, and visiting nurse service.

Administrative problems caused by joint use of facilities and closer relationship among personnel of the hospital and public health agency would have to be solved according to the individual town or city as conditions vary in different sections of the country. In the small community with one hospital and one health department the commission asserts, "it should not be too difficult to secure close physical as well as a close working relationship between hospital and health department. All activities could be in one building or in adjacent buildings and under one director, particularly if both are governmentally operated."

The ideas of separated preventive and curative programs, hospitals and health departments should be changed the commission continues, adding, "The need for a change in these ideas has become increasingly evident as knowledge concerning the prevention of disease has advanced and the appreciation of the value to the public of close cooperation between the fields of public health and curative medicine has grown."

NURSES FAVOR OWN AGENTS IN COLLECTIVE BARGAINING

Milwaukee, Wis., Oct. 30—Discussing the needs and problems of nurses, the Board of Governors of the Wisconsin State Nurses' Association, meeting October 29 at the Hotel Schroeder in Milwaukee, indicated that collective bargaining by nurses should be in the hands of the nurses' organization rather than a labor union.

The executive secretary of the association, Mrs. C. D. Partridge, claimed that the association, a constituent body of the American Nurses' Association, is more capable of judging the needs and problems than any union of mixed or nonprofessional workers.

The Golden Rule

Stating that the ideal condition for collective bargaining is observation of the Golden Rule and the concept of the brotherhood of man, by both management and worker representatives, Mr. Benjamin Feinberg, state president of the United Association of Office, Sales and Technical Employees, addressed the nurses on collective bargaining technique. Under Wisconsin law, Mr. Feinberg declared, the State Nurses' Association may elect its own bargaining agent.

The
MEDICAL FORUM

The Wisconsin Medical Journal December, 1946

WISCONSIN PHYSICIANS SERVICE BEGINS OPERATION

Varied Program of Postgraduate Clinics Planned by State Society For 1947

Cancer, Industrial Medicine Clinics in Spring

The popularity of regional scientific teaching clinics has prompted the Council on Scientific Work to sponsor a varied program of conferences for 1947.

Meeting with representatives of the Committee on Cancer and the Committee on Industrial Health, the Council has arranged two series of postgraduate teaching clinics in addition to the customary "spring clinics" which will be held in late June or early July so as to provide a scientific program for physicians in the northwestern part of the state.

The Committee on Industrial Health, in cooperation with the Industrial Hygiene Unit of the State Board of Health is planning a series of one-day "in plant" meetings which will introduce physicians to actual working conditions in various types of plants, and will provide a degree of practical application of industrial medicine which is lacking in didactic lectures. Present plans call for a series of clinics in late March or early April. Tentative plans provide for clinics at Racine, Fort Atkinson, and Green Bay, with possibly a second series in Wausau, Eau Claire, and La Crosse.

Long-Term Cancer Program

Meeting with the Council on Scientific Work Dr. Warner S. Bump, Rhinelander, chairman of the Committee on Cancer, outlined a comprehensive teaching program which the Committee on Cancer in cooperation with the Wisconsin Division of the American Cancer Society hopes to initiate in 1947. The contemplated program would consist of a series of six one-day regional meetings, conducted in late July and early August and repeated in the same general localities for a six year period. The program, worked out by Dr. A. R. Curreri, Madison, as a member of the Committee on Cancer, would concern itself with diagnosis and treatment of cancer occurring in various areas of the human body. The first year's program would stress cancer of the skin and cancer of the cervix and breast.

W. S. BUMP

Details of all regional scientific clinics will be announced to members of the State Society as soon as completed.

STATE BOARD OF MEDICAL EXAMINERS

At this time the board is preparing the files for annual registration. All doctors returning from service and any others who have not completed the original registration application should contact the State Board of Medical Examiner's office immediately in order to be included in the 1947 registry.

PHYSICIAN PARTICIPATION IN W. P. S. PLAN INCREASES

Madison, Dec. 17—With inquiries from groups in several parts of the state who are interested in Wisconsin Physicians Service coverage, Wisconsin Physicians Service was made available December 1 by direction of the first phase of the mandate by resolution of the State Medical Society's House of Delegates. This resolution provided for establishing the plan and having it in operation on December 1, 1946.

Executive offices have been acquired in the Washington Building, 119 East Washington Ave., Madison, it is reported by Mr. Ralph F. Weber, acting director of Wisconsin Physicians Service. Mr. R. S. Saylor of Milwaukee, formerly director of Surgical Care, has joined the administrative staff.

Physician participation in Wisconsin Physicians Service is now reported at 1,596 out of a possible active membership of 2,370. Milwaukee County has 350 doctors participating out of a possible 802.

The subscriber contract adopted for Wisconsin Physicians Service and which has received favorable comment from Blue Cross, is as follows:

Wisconsin Physicians Service

SURGICAL-MEDICAL SERVICE CONTRACT

Definitions

Services and Participating Doctors—The term "services" as used herein shall mean professional services rendered to the subscriber by a physician and surgeon of the subscriber's own choice, who is licensed by the state board of medical examiners to practice in Wisconsin, hereinafter referred to as "doctors", and who are registered as participating with Wisconsin Physicians Service, for illness or injury requiring and resulting in admission and care as a bed patient of a participating

(Continued on page 4, column 1)

FILL OUT FORMS COMPLETELY, VETERANS MEDICAL SERVICE AGENCY URGES PHYSICIANS

Madison, Dec. 2—As the Veterans Medical Service Agency finds some of the recommendations on Form 100, sent out to physicians to be filled in when they render service to veterans in connection with the agency, incomplete, Mr. Thomas J. Doran, director of the agency asks physicians to notice the following points:

1. If payment is expected for the first office visit or first home visit, it must be marked down under office visit or home visit.
2. Authorization cannot be secured for services rendered if they are not clearly indicated.
3. If a home visit that calls for mileage is made, the number of miles should be stated so the agency can secure specific mileage authorization.
4. The treatment patients receive depends a good deal on the recommendation made on the Form 100.
5. Estimates should be made clear, specific, and adequate.
6. The code number in the fee book should be employed whenever possible.
7. The more information listed under clinical history and positive findings, the easier it is for authorization to be obtained.

It has been suggested that the physician tear off the last copy of the Form 100 to use as a work sheet. The information from that sheet can then be typed on the other three copies that must be forwarded to the agency.

Laboratory and X-ray Work

When a physician is authorized to give a veteran needed clinical, laboratory, or x-ray work for which he is not equipped, he should have the work done by another who is so equipped and list that work on his bill. After the bill is paid, the physician then pays the clinician or laboratory man. If the work and billing are not handled in this way the clinician or laboratory man will have to receive separate authorization for the work. As soon as contracts are accomplished between the Veterans Medical Service Agency and the hospitals and laboratory men, this procedure will be changed, Mr. Doran reports, but for the present the above mentioned method will speed payment for the work performed.

Hospital Relations Conference Being Planned For Next Spring

The Committee on Hospital Relations has requested the Council on Scientific Work to discontinue the Section on Hospital Relations as a formal section of the Annual Meeting, and steps are being taken to incorporate this activity under the Council on Medical Service and Public Relations with the idea of sponsoring a series of nontechnical meetings between hospital administrators and physician staff members. This will be a means of airing some current problems common to the medical profession and the hospitals of Wisconsin.

"Experience has demonstrated the need for a different type of meeting than presented at the Annual Meeting," said Dr. J. E. Habbe, Milwaukee, chairman of the Committee on Hospital Relations, in commenting upon the new plans of the committee. "We feel there is a real need for a joint conference between staff physicians and hospital administrators, but we feel it can be carried on most effectively if presented on a regional basis and given at a time other than the Annual Meeting, when physicians are most anxious to attend the scientific sessions held concurrently with the Section on Hospital Relations."

J. E. HABBE

If the Council on Medical Service and Public Relations indicates an interest in sponsoring a series of joint conferences with hospitals in cooperation with the Committee on Hospital Relations, it is intended that a trial meeting will be conducted in the Fox River Valley area in late May or early June of 1947. Representatives of the Wisconsin Hospital Association and the Wisconsin Conference of Catholic Hospitals will be asked to assist with the planning of the program.

STOVALL, SCHMIDT ATTEND CANCER INSTITUTE MEETING

Washington, D. C., Nov. 14—A special committee composed of representatives of 14 medical schools including the University of Wisconsin Medical School, Madison, and of the National Research Council met November 7 with the National Advisory Cancer Council to discuss the place of cancer in the medical school curriculum.

The meeting, held at the National Cancer Institute, Bethesda, Md., marked an advance in efforts to eliminate the lag between what is known about cancer and the application of this knowledge in medical practice, according to a report from U. S. Public Health Service.

Wisconsin Representatives

Dr. William D. Stovall, Sr., professor of hygiene, and Dr. Erwin R. Schmidt, professor of surgery, School of Medicine, the two University of Wisconsin representatives on the special committee were present at the meeting.

Dr. Frank E. Adair, president of the American Cancer Society and chairman of the committee, declared it is obvious that something must be done to improve the education of medical students in cancer which ranks second as a cause of death in the United States. The teaching of medicine has become more and more difficult due to the vastness and intricacy of the field, and many educators recognize the need for changes in the curriculum.

Among the suggestions made for improving the medical curriculum were the establishment of professorships in clinical cancer, greater use of the facilities of cancer diagnostic and treatment clinics and cancer prevention clinics, the establishment of cancer institutes or hospitals in connection with medical schools in large urban centers, and greater emphasis in the medical school on the importance of preventive medicine.

NEUPERT ELECTED TO SERVE ON APHA EXECUTIVE BOARD

Madison—Dr. Carl N. Neupert of Madison, State Health Officer, was recently elected by the governing council of the American Public Health Association to serve on the association's executive board for a term of two years.

The elections were held during the American Public Health Association's annual meeting in Cleveland the week of November 11.

Doctor Neupert is now one of the six members of the A. P. H. A. executive board who conduct the business of the association between meetings. Headquarters of the association are in New York City.

COUNCIL WILL MEET

The annual meeting of the Council of the State Medical Society of Wisconsin will be held on January 25 and 26, 1947.

SOCIALIZED MEDICINE DISCUSSED IN EDITORIAL

In a recent editorial that appeared in the Marinette Eagle-Star reporting on the Wagner-Murray-Dingell Bill Senate Committee hearings, it was pointed out that "the manner in which hearings on the political medicine bill were conducted was surreptitious."

Of the 62 witnesses who appeared in support of the bill, 16 were on the government pay roll. Representatives of leftist organizations composed another group of 11 witnesses, the editorial asserts. Several hundred physicians who petitioned to testify against the bill were prohibited from appearing before the committee.

According to the editorial, Dr. Ernest E. Irons, president of the American College of Physicians, speaking of proposed socialized medicine stated in part: " 'And this proposal is more serious in its implications for our democracy than even for medicine itself. It is part of a deeper plan evolved by a few seekers after power who, under the guise of social betterment, would change our democracy through the centralization of power in bureaucracies into a totalitarian government.' "

"Such leaders in the medical profession as Dr. Irons have not conjured up fake alarms . . ." the editorial explained. "The Union for Democratic Action, for example, was one of the organizations ostensibly formed to develop 'real democracy in government' and gave vigorous support for the political medicine bill. One Lewis Corey had connections with this organization's research department. And who is Lewis Corey? For many years he was known in the International Communist world as Louis Fraina and was the first Communist editor in the United States."

The editorial concludes with the thought that of the numerous reasons why socialized medicine should be rejected by Congress, one of the more important is the established fact that the bill has the support of the Communists.

NORTH CENTRAL MEDICAL CONFERENCE MEETING, ST. PAUL

Emphasizing that the American Medical Association provides the means by which the physician can accomplish his purposes, that the A. M. A. is deserving of the support of every physician, and only through his active constructive participation can it accomplish its goal, Dr. J. D. McCarthy of Omaha, president of the North Central Medical Conference, keynoted the session of the conference held at St. Paul, Minnesota, November 10.

Those physicians and surgeons from Wisconsin present at the conference meeting were: Drs. R. G. Arveson, Frederic; H. A. Sincock and V. E. Ekblad, Superior; C. O. Vingom, J. S. Supernaw, and W. D. Stovall, Madison; S. E. Gavin, Fond du Lac, J. W. Truitt, Milwaukee, and C. A. Dawson, River Falls. There were about 75 physicians from Nebraska, North Dakota, South Dakota, Iowa, Minnesota, and Wisconsin attending the meeting held in conjunction with one of the regional meetings of the A. M. A. Council on Medical Service.

In an impromptu speech at the conference, Dr. W. F. Braasch, Rochester, Minnesota, a member of the Board of Trustees, urged understanding and cooperation as against constructive criticism. He felt that there were bound to be mistakes in an organization so large but that, by and large, medicine is moving steadily forward.

"In a year or two the do-builders and uplifters will be back in the picture," one of the speakers, Dr. E. J. McCormick of Toledo, Ohio, chairman of the Council on Medical Service of the A. M. A., asserted, and cautioned the profession to be "ever on guard." He then summarized the status of prepaid medical care plans, mentioning that their roll had increased 45 per cent since the first of the year, and that in only three states, Mississippi, Nevada, and South Dakota, was there no plan either operating or contemplated at the present time.

Medical Examiners to Meet in Madison, January 14-17

The State Board of Medical Examiners will meet in Madison at the Hotel Loraine, January 14, 15, 16, and 17, 1947 to examine applicants for medical licensure in the state.

INCOME PROTECTION

Injury and illness are a constant hazard to every income.

Accident, Health, Hospital and Surgical Insurance softens the blow of unexpected disability.

For BALANCED protection, write TIME.—The leading Wisconsin Company in this specialized field of insurance.

The Time Insurance Company

213 W. Wisconsin Ave.
Milwaukee 3, Wis.

WISCONSIN PHYSICIANS SERVICE CONTRACT—

(Continued from page 1)

doctor in a Wisconsin hospital acceptable to Wisconsin Physicians Service, to the extent and subject to the limitations set out in this Contract.

Subscriber—The term "subscriber" as used herein shall mean any person to whom Wisconsin Physicians Service shall issue a Subscriber's Contract and an Identification Card.

Dependent—The term "dependent" as used herein shall mean the husband or wife of the subscriber, and all unmarried children (principally supported by the subscriber) under 19 years of age, who live with the subscriber.

Participant—The term "participant" as used herein shall mean the subscriber or a dependent.

Service Benefits

1. Following are the service benefits under this Contract:

Surgical Services—(a) Surgical services (including operative and cutting procedures for treatment of disease and injuries, and treatment of burns, fractures and dislocations) rendered by the doctor in charge of the case.

Diagnostic X-ray Services—(b) Diagnostic x-ray services, performed outside of a hospital, immediately preceding surgery or in connection with fracture or dislocation reduction, not in excess of the value of Ten Dollars ($10.00), per contract per year, as set forth in and limited by the Wisconsin Physicians Service Schedule of Service Benefits, between the effective date of this Contract and the first anniversary hereof, or during any succeeding twelve-month period.

Anesthesia Services—(c) Anesthesia services rendered by a doctor not in charge of the case, and other than a salaried employee of the hospital, when in connection with services otherwise provided hereby in the hospital where the subscriber is a patient.

Emergency Services—(d) Emergency surgical services, not requiring bed care, rendered in a hospital acceptable to Wisconsin Physicians Service, by a doctor during the first twenty-four hours following accidental injury.

Medical Services—(e) Medical services, while a bed patient in a hospital; provided that payment for such medical services shall not cover those rendered the first three days nor after the thirteenth day in such hospital; and provided further, that no participant shall be entitled to an aggregate of more than ten days of such services between the effective date of this Contract and the first anniversary hereof, or during any succeeding twelve-month period.

Maternity—(f) Maternity services are provided only on a family contract, and include the usual prenatal, delivery, and postnatal care; provided that this Contract must have been in force for nine consecutive months before the delivery, and that such services shall be available only to a subscriber or his spouse.

Services in-Full to Subscriber—2. This is a service contract in which participating doctors agree, irrespective of the amount of compensation available to them, to perform professional services for covered persons within specified income limits. Doctors participating with Wisconsin Physicians Service and rendering to the subscriber such services as are herein provided shall be paid direct by Wisconsin Physicians Service, and shall make no added charge to the subscriber therefor, except:

Exception to Full Services—(a) To an unmarried subscriber whose annual income exceeds Two Thousand Dollars ($2,000); or

(b) To a married subscriber whose annual income, together with that of his dependents, exceeds Three Thousand Six Hundred Dollars ($3,600).

Added Fees, When Allowable—In the event services covered by this Contract are rendered to subscribers subject to exceptions (a) or (b) of this paragraph, the doctor participating with Wisconsin Physicians Service may make an additional charge to the subscriber; such additional charge, if any, shall be the liability of the subscriber and not of Wisconsin Physicians Service.

Disputed Income Classification—In the event of any dispute between the doctor and the subscriber with respect to the application to such subscriber of the provisions of exceptions (a) or (b) of this paragraph, the same shall be submitted to and determined by Wisconsin Physicians Service, whose determination shall be binding upon the parties.

General Limitations

3. This Contract is subject to the following general limitations, exclusions or conditions:

Identification—(a) *The Subscriber's Identification Card must be presented to the doctor when service is requested;* otherwise, the income limits contained in subparagraph (a) and (b) of paragraph 1, above, shall not apply.

Exclusions from Service Benefits—(b) The service benefits of this Contract, as set forth above, shall exclude the following:

(1) Hospital, dental, or nursing services.

(2) Medicines, drugs, appliances, materials, or supplies.

(3) Services for industrial injuries or diseases, or services from any governmental agency, which are, or to the extent that such services can be, obtained by the subscriber, without cost to him, by compliance with laws or regulations (including Workmen's Compensation Statutes) enacted by any federal, state, municipal, or other governmental body.

(4) Plastic operations for cosmetic or beautifying purposes.

(5) Medical services, except as provided in subparagraphs (b), (c) and (e) of paragraph 1, above.

Services of Non-Participating Doctor—(c) If benefits provided by this Contract are rendered by a doctor not participating with Wisconsin Physicians Service, it will pay its then prevailing benefit for such services.

Renewal, Termination and Grace Periods

4. Following are the renewal, termination and grace provisions of this Contract:

Term and Termination—(a) This Contract shall be in force for one month from its effective date, as shown on the Subscriber's Indentification Card, and shall be renewed thereafter each month, by payment of the subscription rates then in effect, unless notice of election to terminate the same is given by either party to the other, not less than thirty days prior to the date of termination. In the event the remitting agency of the group through which the subscriber is enrolled shall default, for any reason, in making the advance payments to Wisconsin Physicians Service then in effect, or shall give notice to Wisconsin Physicians Service of its intention not to collect and remit such payments, this Contract shall terminate at the

(Continued on next page)

Council on Scientific Work Names Dr. F. C. Midelfort to Plan 1947 Meeting

Dates of Next Meeting Announced

Milwaukee—Meeting in Milwaukee November 16 the Council on Scientific Work elected Dr. C. F. Midelfort, La Crosse, chairman for 1947 and asked him to assume the responsibility of preparing the scientific programs for the 1947 Annual Meeting, which will be held in Milwaukee October 6–7–8, following action of the general Council of the Society.

The scientific exhibits for the 1947 Annual Meeting will be handled by Dr. J. M. Freeman, Wausau; Dr. H. Kent Tenney, Madison, will select the motion pictures to be shown as a teaching feature of the meeting; and Dr. F. W. Madison, Milwaukee, will assist Doctor Midelfort by arranging for patients used in connection with the clinical demonstrations, which are to be repeated in 1947 as a result of their popularity this past year.

Neidhold Plans Postgrad Clinics

The Council on Scientific Work also named Dr. C. D. Neidhold, Appleton, as chairman of the Postgraduate Teaching Clinics for 1947. Tentative plans call for a series of clinics in late June or early July, starting in the southwestern part of the state, proceeding to Eau Claire or Chippewa Falls, and ending at Superior, where a joint clinic for physicians in northern Wisconsin and the Duluth area of Minnesota will be held.

NEWS OF PREPAYMENT MEDICAL CARE PLANS

California Physicians Service, a voluntary prepaid medical care plan, in November teamed up with similar plans in seven other states (Arizona, Colorado, Montana, New Mexico, Oregon, Texas, and Washington) to set up a system of reciprocal services which will cover a million members.

California Physicians Service offers doctor's care, nursing, consultation with specialists, and hos-

(Continued on page 7, column 2)

W. P. S. CONTRACT—

(Continued from page 4)

end of the month for which such payments have been made.

Grace Period—(b) Where either a subscriber or a remitting agency has failed to make advance payment of subscription rates and this Contract has lapsed, Wisconsin Physicians Service shall reinstate this Contract if such delinquent payment is made by the end of the month for which such payment is due and earned.

Subscriber Leaving Group—(c) When a subscriber ceases to be employed or affiliated with the group with which his application for membership was accepted, he may continue his membership by becoming re-employed where a Wisconsin Physicians Service group already exists, or by making his payments directly to the Wisconsin Physicians Service office, or to any authorized agent, subject to the rates and contract provisions in effect at that time. When for any reason other than fraud, a person is no longer eligible to remain a dependent, he may, within thirty (30) days after the close of the month in which he ceases to be eligible as a dependent, apply for a separate contract either through a Wisconsin Physicians Service group with which he is employed, or by making his payments directly to the Wisconsin Physicians Service office, or to any authorized agent, subject to the rates and contract provisions in effect at such time. If and when a subscriber or former dependent converts or takes a contract on a direct payment basis, it is understood that Wisconsin Physicians Service will endeavor to forward notices of remittances due; however, *the responsibility for payments rests solely with the subscriber.*

Miscellaneous

5. Following are the miscellaneous provisions of this Contract:

Adding New Dependents—(a) Dependents of a subscriber, who become such while this Contract is in force, will be entitled to the benefits hereunder beginning thirty (30) days following the first day of the succeeding month after the subscriber has certified the said dependents in writing to the satisfaction of Wisconsin Physicians Service. Such certification must be made to Wisconsin Physicians Service either within sixty (60) days from the time the dependent became such or within thirty (30) days prior to an anniversary of the date shown on the Identification Card of the subscriber.

Subscriber-Doctor Relationship—(b) The subscriber shall be free to select his own physician from among the participating physicians. He shall likewise be free to discharge his physician. The physician shall be free either to provide care or service, or not, in accordance with the custom and practice prevailing in the private practice of medicine. Nothing herein contained shall interfere with the ordinary relationship which exists between a physician and his patient; nor shall it obligate Wisconsin Physicians Service under any circumstances to supply a physician for the subscriber.

Reports on Services Rendered—(c) Doctors participating with Wisconsin Physicians Service are required to furnish reports to it which shall remain confidential, relative to diagnosis and services given the subscriber entitled to or claiming such services under this Contract, and it is agreed that request for such services shall also operate as authorization to the doctor to make such reports covering the person treated.

Assignment—(d) The services to be provided under this Contract are for the personal benefit of the subscriber and eligible dependents, and cannot be transferred or assigned. Any attempt to assign this Contract shall automatically terminate all rights hereunder.

Contest—(e) No action at law, or suit in equity shall be commenced until thirty days after written notice of claim has been given by the subscriber to Wisconsin Physicians Service, nor shall such action be brought later than two years after such claim has arisen by acceptance of services.

Contract Continuity of Benefits—(f) The Application submitted by the subscriber, this Contract and the Identification Card are the entire agreement between the parties. No agent or employee is authorized to vary, add to, or change any part of the agreement as set forth, in any manner or degree, except to make necessary and proper insertions in blank spaces. The issuance of this Contract cancels all others in force and all rights thereunder between the subscriber and Wisconsin Physicians Service.

STATE FARM BUREAU FAVORS VOLUNTARY HEALTH PROGRAMS AND CLOSE COOPERATION WITH SMS

Federation Delegates Express Views of 20,000 Members

Madison, Nov. 20—Concluding a three-day session, in which delegates of the Wisconsin Farm Bureau Federation reviewed current agricultural problems, including that of rural health, the powerful farmers' organization, representing more than 20,000 members in the state took a firm stand against compulsory health plans, and urged close cooperation with the State Medical Society in its program of developing health insurance on a voluntary basis.

The resolution covering voluntary hospitalization plans was adopted in the following form:

"We favor the development of voluntary hospitalization and medical care insurance plans and are unalterably opposed to any compulsory hospitalization insurance plan.

"We request the Wisconsin Farm Bureau Federation to secure any arrangement of hospitalization insurance plans that meets adequately the requirements of the farmer and suggest cooperation with the Wisconsin Medical Association in securing such a standard agreement. The plan secured should be of such cost that the farmer can afford and yet secure the necessary and essential protection."

OK's State Board of Health Program

A second resolution presented and passed, approved the extension of public health facilities into rural areas by creating more and smaller public health districts, and supported the request of the State Board of Health for enlarged facilities of the state laboratory of hygiene. The stand of the Farm Bureau was expressed in the following terms:

"We recognize the inadequacy of the present health and hospital facilities in many of the rural areas of Wisconsin. We urge that necessary state funds be provided to match federal funds appropriated by the last Congress so that the health facility needs can be met in the state. We commend the state board of health for its vision in conducting a survey to determine the extent of the present medical facilities so that judicial planning can proceed. We will support necessary legislation to place this program in operation.

"We urge that in order to more adequately serve the people of this state the present health districts should be reorganized and made smaller in size.

"There is also apparent need for a new and enlarged state laboratory of hygiene in Wisconsin."

STANDARDS FOR HOSPITAL CONSTRUCTION DRAFTED BY USPHS DIVISION

Washington—The Hospital Survey and Construction Act, authorizing a nationwide program of hospital construction, requires that standards of construction and equipment be established by the Surgeon General, U. S. Public Health Service. After consultation with the Federal Hospital Council, these standards, which will apply to all projects to be built with Federal assistance under this legislation, have recently been drafted by the Office of Technical Services, Division of Hospital Facilities, U. S. P. H. S. The Committee on Hospitalization and Public Health of the American Institute of Architects approved the standards and submitted them to a special technical committee on architectural standards appointed by the Federal Hospital Council which met in Washington on November 12 and 13.

After review and approval by this committee, the standards were accepted by the Federal Hospital Council and will be incorporated in the Rules and Regulations of the Hospital Facilities Division. The Surgeon General and the Federal Security Administrator will have to approve the Rules and Regulations before they are published and made available to all persons interested in this program. The Act requires that these regulations be promulgated not later than February 13, 1947.

Five Classifications

The standards established, which fall into five classifications: site, architectural, structural, mechan-

(Continued on page 7, column 1)

COUNTY SYSTEM OF MEDICAL AID DEFEATED; WINNEBAGO

The second attempt to have Winnebago County placed on a countywide system of medical and hospital relief for old age assistance, aid to dependent children, and aid to the blind was defeated by the Winnebago County Board at its November 19 session.

A resolution, establishing a fund of $10,000 in the 1947 budget to be used to pay hospital and physician bills of those people on county pensions, was tabled by a vote of 22 to 16. Principal objectors to the resolution, supervisors of rural townships in which such bills are met by township expenditure, declared that each municipality should care for its own people. This same objection defeated an identical resolution that was presented a year ago.

Doctors and hospital officials pleaded for consideration of the countywide relief system in which the medical bills paid by the county would receive a 25 per cent discount by the doctors and the state would pay 35 per cent. Reports were given about county pensioners at hospitals who are receiving treatment for which the hospitals are receiving little or no pay. The maximum of $45 which people on old age pensions obtain per month was reported to be scarcely enough to meet costs of living and clothing, exclusive of medical care.

STEELE SELECTED FOR VA POSTGRAD MEDICAL EDUCATION COMMITTEE

Dr. John D. Steele, Milwaukee physician, was among the 70 prominent medical men selected by the American Trudeau Society recently to serve on its national and regional committees on postgraduate medical education, Dr. Paul R. Hawley, chief of the Veterans Administration's medical service, has announced. The American Trudeau Society is the medical section of the National Tuberculosis Association.

"The selection of these physicians to serve on these committees is an outstanding recognition of the types of men who today are serving VA as consultants in tuberculosis and full time in tuberculosis service," Doctor Hawley declared.

Doctor Steele is consultant in thoracic surgery at Wood and Waukesha VA hospitals.

HOSPITAL CONSTRUCTION

(Continued from page 6)

ical, and drawing specifications, constitute the minimum requirements considered necessary to insure properly planned and well constructed hospitals and health centers. But since they are minimum requirements, it is pointed out that they should form a basis only for the development of higher standards.

There has been no attempt, in establishing these standards, to make them coincide with all of the various state and local codes and regulations. However, strict compliance with all applicable state and local regulations is required as is compliance with minimum standards of construction and equipment promulgated by the state agency administering this program, where such standards are higher than those established by the Surgeon General.

CHIROPRACTORS FILE SUIT CONCERNING LICENSE LAW

Madison, Dec. 2—Five Wisconsin Society of Chiropractors members today in Circuit Court, Madison, filed suit in an attempt to enjoin the Wisconsin State Board of Examiners in Chiropractic from refusing licensure to qualified chiropractors because they failed to attend a 1945 meeting of the Wisconsin Chiropractic Association.

A statute which provides for renewal of license only if the applicant has attended at least one of the two meetings held by the Wisconsin Chiropractic Association during the preceding year was the basis for the examining board's action.

The plaintiffs in the action are asking the court to order issurance of licenses denied because of the statute and to rule on the validity of the law.

They also seek to prevent legal action being taken by the examiners against chiropracters practicing without a license where the license has been denied on the basis of the contested statute.

The complaint contends that the chiropractors society conducts its own educational meetings, and declares that it is a violation of constitutional right to enforce attendance at the association's meetings where a $10 fee is charged.

United Mine Workers' Demands Include Health, Hospital, and Medical Service

The Medical Society of the State of Pennsylvania reports on two demands of the United Mine Workers that directly affect health, hospital, and medical service to the miner.

These demands are: first, the creation of a welfare fund by a five cent royalty on every ton of coal mined in the bituminous coal area of the United States; this fund to be used for the purpose of improving sanitation, housing, and augmenting unemployment expense. In the first six weeks of operation the fund accumulated approximately $3,500,000. This fund is to be administered by a representative of the United Mine Workers, a representative of the operators, and one individual selected by these two.

The second fund is a payroll deduction from the miners to provide for medical care and hospitalization. This fund will be administered by local district United Mine Workers presidents.

Administration by Single Group

The Medical Society of Pennsylvania believes the medical profession should realize that this is a new type of social philosophy which involves the control of health and medical services to this group of people by the United Mine Workers, and that this type of control may produce a questionable quality of service. Also that the administration of these funds is largely in the hands of a single group. The personnel of the employers are being used to collect these funds, with no representation in their administration. The public will be charged additional for coal and will have no definite representation on either of these funds. The medical profession will be required to provide the service and have no representation. This does not seem to be conducive to efficient administration, the Medical Society of Pennsylvania feels.

That Society also believes that the medical profession should consider in its contacts with those administering the funds that a high quality of service be guaranteed the people and that in order to obtain a high quality of service that representatives of the medical profession should be selected to serve on the administrative boards.

PREPAYMENT CARE—

(Continued from page 5)

pitalization for industrial groups with individual incomes under $3,000. C. P. S., with 92 per cent of California's physicians enrolled and 400,000 patients, has fees ranging from $2.50 monthly for a single person to $5 per family.

Of the new system William M. Bowman, C. P. S. director, declared, "We expect to see this reciprocity arrangement roll like a barrel clear across the country."

MEDICAL ASSISTANTS IN MILWAUKEE ORGANIZE

Milwaukee, Dec. 12—Medical assistants, technicians, nurses, and physicians' secretaries have formed an organization in Milwaukee which has demonstrated its value as a public relations contact.

Originally organized in the early months of 1945, the Milwaukee Medical Assistants' Association under the sponsorship of the Medical Society of Milwaukee County, has taken an active part in the solicitation of funds for the operation of the cancer detection center in Milwaukee, assisted with the exhibit of the cancer detection center at the Health Show last spring, and conducted a series of meetings at which members have been addressed by physicians and workers in the field of social service.

The organization has also given the various members the opportunity of participating in the Blue Cross Hospitalization Plan which previously had been inaccessable to each girl as an individual.

On the basis of its experience the Milwaukee Medical Assistants' Association is anxious to launch a state-wide organization. It is suggested that physicians call this matter to the attention of their secretaries, and all those interested in forming similar units are urged to correspond with Miss Ruth Taylor, president, at 208 East Wisconsin Avenue (Suite 753) Milwaukee 2.

As the January *Journal* is the Blue Book Issue, there will be no Medical Forum section next month.

QUESTIONNAIRES SENT OUT; STUDY RESULT TO AID MEDICS IN EMERGENCIES

Postwar Question Sheets Mailed to Discharged Medical Officers

Chicago, Nov. 15—Dr. Edward L. Bortz, of Philadelphia, chairman of the Committee on National Emergency Medical Service of the American Medical Association, has announced the mailing soon of a comprehensive questionnaire to more than 45,000 discharged medical officers of World War II.

"Since the results of the questionnaire will serve as a useful guide in preparing for any new national emergency," Doctor Bortz said, "the committee urges all the returning medical officers to express frankly, fully and completely their reaction to military service."

The questionnaires were mailed from A. M. A. headquarters in Chicago during November and should be returned within a month. The results will be tabulated and analyzed in detail.

Letter Accompanies Questionnaire

The following letter, signed by Dr. George F. Lull, secretary and general manager of the A. M. A., in behalf of the committee accompanied each questionnaire:

"The House of Delegates of the American Medical Association in December 1945 created a committee to study the over-all needs and utilization of medical skills and resources of the nation in the case of an emergency. The House passed the following resolution:

'. . . that the Association undertake a critical study of the duties of medical officers during the war just passed, with special reference to (1) opportunities for study, research and actual treatment of the sick; (2) rotation of medical assignments; (3) quasi-medical duties for which technicians and specially trained enlisted personnel might replace physicians . . .

'. . . and appoint a special committee to study by means of questionnaires sent to medical officers on release from active duty. . . .'

"The Board of Trustees has appointed a National Emergency Medical Service Committee and instructed it to undertake the study and prepare plans as described in the action of the House of Delegates.

"A pilot questionnaire was sent to 1,000 former medical officers, selected at random. The response was surprisingly large. A total of 470, or 47 per cent, of those questionnaires were carefully filled out and returned. Certain technical defects in the pilot questionnaire form were noted and the revised questionnaire enclosed herewith was developed. It is being sent to all former medical officers, including those who received the pilot questionnaire.

"The Committee is a fact finding board and hopes to make recommendations that will lead to better utilization of medical skills and resources in a future emergency. Your help in this will be appreciated. A stamped envelope is enclosed for your early return of the completed questionnaire. You are cordially invited to write a covering letter if the questionnaire has omitted points which you deem significant."

Doctor Bortz said that the committee feels that its final analysis and recommendations should cover not only the military services, but also other governmental agencies, industry, medical education, research, and civilian medical care.

The committee, in so far as possible has provided check lists in this questionnaire. This makes it possible for the doctor merely to check the proper item and avoid taking the time to write out his answers.

Some of the questions will require written explanations, however. For example: What important features of training were not sufficiently stressed? What in your opinion should be included in an ideal training program? If there was waste of personnel in your unit, please state how personnel could have been used effectively. What suggestions have you about methods of assignment of medical officers in the event of another military emergency?

In discussing the questionnaire, Doctor Bortz stressed the desirability of deliberation on the part of every physician in answering the questions. "The objective sought," he said, "can be best attained by careful consideration of each and every question."

Committee Members

In addition to Doctor Bortz, the National Emergency Medical Service Committee is composed of Dr. Harold S. Diehl, University of Minnesota, Minneapolis; Dr. Perrin H. Long, Baltimore; Dr. Harold C. Lueth, University of Nebraska, Omaha; Dr. O. O. Miller, Louisville, Ky.; Dr. James C. Sargent, Milwaukee; and Dr. V. C. Tisdal, Elk City, Okla.

Postwar Questionaire

A copy of the Postwar Questionnaire sent by the American Medical Association's Committee on National Emergency Medical Service to more than 45,000 discharged medical officers of World War II appears on the following two pages of *The Journal*.

FOUNDATION SEEKS AID IN RESTORATION OF "MEDICAL SHRINE"

Madison—The Beaumont Fountion, formed to establish an historic memorial to the pioneer scientist, Dr. William Beaumont, at the site of his experiments, is soliciting support and cooperation throughout Wisconsin to aid in restoring the "medical shrine" in Crawford County.

Dr. Walter J. Meek, assistant dean of the University of Wisconsin Medical School, is chairman of the foundation's advisory board, and Dr. William D. Stovall, director of the State Laboratory of Hygiene, is the chairman of the board of directors.

Hospital Being Restored

The organization has acquired two acres of the old Fort Crawford land in Prairie du Chien, property valued at $20,000, and is working on the restoration of the hospital in which Doctor Beaumont carried on his experiments more than a century ago. As more funds are needed to complete the buildings and provide public exhibits, solicitation is being conducted with the aid of the Crawford County Historical Society, the local county medical society, the State Medical Society, and the D. A. R.

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